



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 7, 2024

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

RE: CCN: 245293
Cycle Start Date: October 2, 2024

Dear Administrator:

On October 31, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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

PRINTED: 10/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2024
NAME OF PROVIDER OR SUPPLIER HOPKINS HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 10/1/24 through 10/2/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed during the survey: H52938880C (MN00106925). As a result of the investigation, deficiencies were cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		10/24/24

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

TITLE

(X6) DATE

Electronically Signed

10/25/2024

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 609	<p>Continued From page 1</p> <p>hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure an allegation of physical staff to resident abuse was reported timely, within two hours, as required to the State Agency (SA) and to the administrator for 1 of 1 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's significant change Minimal Data Set (MDS) dated 6/25/24, indicated R1's diagnoses included dementia and personality disorder. R1's cognition was not impaired.</p> <p>Review of facility report number 358043 submitted to the SA on 9/24/24 at 5:41 p.m., identified R1 had reported a nursing assistant (NA) while providing cares was angry and telling</p>	F 609	<p>It is the policy of Hopkins Health Services to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. This policy includes the requirement to to report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies. This must be done immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>Immediately after concerns were noted in</p>	

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F 609	<p>Continued From page 2</p> <p>R1 not to use the call light and it made her angry. R1 reported NA pinched her in the left leg and grabbed her hair with water on her hands. R1 was able to identify the staff as NA-A.</p> <p>On 10/2/24 at 10:32 a.m., licensed practical nurse (LPN)-A stated staff were expected to report allegations of abuse to the nurse manager, director of nursing (DON) and administrator immediately.</p> <p>On 10/2/24 at 10:41 a.m., LPN-B stated the facility's abuse policy required staff to report allegations of abuse "right away" to their immediate supervisor and the allegation would need to be reported to the SA within two hours. Further, LPN-B stated they were notified by LPN-C at approximately 1:00 p.m. on 9/24/24, R1 had reported a NA had pinched her. LPN-B stated they notified DON and administrator.</p> <p>On 10/2/24 at 10:57 a.m., social services (SS)-A stated staff were expected to report allegations of abuse "immediately" and report to the administrator and DON who were then required to report to the SA within two hours. SS-A stated they were informed on 9/24/24 at approximately 2:00 p.m., by LPN-C who reported R1 made an allegation she was hit and pinched by NA-A. SS-A stated they notified the administrator and they both went to interview R1. Further, SS stated LPN-C was made aware of R1's allegation at approximately 11:30 a.m., and LPN-C had reported the allegation to LPN-B as required however, LPN-B directed LPN-C to report the allegation to the administrator and SS-A. SS-A stated she was unsure why LPN-C waited until 2:00 p.m., to report R1's allegation to SS-A however assumed due to medication</p>	F 609	<p>the survey exit, on 10/2/24, LPN B and LPN C were provided a teachable moment related to requirement for Abuse & Neglect Reporting. Both expressed in writing that the they understood and would comply with the requirement that they must report any allegation of Abuse or Neglect to the Administrator IMMEDIATELY.</p> <p>On 10/17/24 Center employees, the IDT team, the Executive Director and contracted services were provided with comprehensive education for "Resident Abuse Prevention and Reporting" with a Post Test requirement results were reviewed for quality of comprehension and understanding. Questions related to consequences of failure to report and how soon should suspected abuse be reported (Questions 6 and 7 on attached survey) were all answered correctly.</p> <p>Ongoing Abuse Prevention and Reporting education will continue to be provided for all new employees and for existing employees, on an as needed basis and annually at a minimum.</p> <p>On 10/16/24 the Administrator was coached from his VP of Success on how to streamline the investigation process in order to ensure timely reporting of Abuse to the MDH.</p> <p>All future incidents will be reviewed, audited for compliance. These results will be identified in investigations of abuse for 6 months and reviewed at future</p>	

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F 609	<p>Continued From page 3</p> <p>administration and meal service LPN-C was busy. SS-A stated she was unsure if LPN-C had been re-educated regarding reporting requirements as the administrator would have addressed that.</p> <p>On 10/2/24 at 11:14 a.m., administrator stated staff were trained annually regarding the facility's abuse policy and staff were required to report an allegation of abuse immediately, but within two hours, to the administrator. Administrator stated he then had to investigate if the allegation of abuse was expected to be reported to the SA within two or 24 hours based on if there was actual harm or injury. Administrator stated he was notified by SS-A of R1's allegation at approximately 2:00 p.m. on 9/24/24. Further, administrator stated he educated LPN-C verbally regarding reporting immediately however did not have evidence of addressing reporting requirement.</p> <p>On 10/2/24 at 11:31 a.m., LPN-C stated staff were provided abuse training but could not recall how often. LPN-C stated staff were expected to report allegations of abuse to their supervisors immediately. Further, LPN-C stated at approximately 11:30 a.m. on 9/24/24, LPN-C was administering R1's medications when R1 reported staff had "pinched" and "hit" her. LPN-C stated she reported this allegation to LPN-B after exiting R1's room. LPN-C stated she was directed by LPN-B to report the allegation to SS-A however SS-A was in a care conference and "it was a busy day" so LPN-C was not able to connect with SS-A until after lunch. In addition, LPN-C stated she was aware allegations of abuse were to be reported right away. LPN-C confirmed the administrator had not re-educated her regarding reporting requirements and had not spoken to the</p>	F 609	scheduled QAPI meetings.	

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F 609	Continued From page 4 administrator since 9/24/24. On 10/2/24 at 11:42 a.m. administrator confirmed he did not report R1's allegation to the SA until 5:41 p.m., due to "there was a lot going on" and by the time administrator interviewed NA-A "it was close to the two-hour timeframe, I don't know". Review of facility policy titled Abuse, Neglect and Exploitation revised 7/15/22, indicated staff were expected to report all alleged violations to the administrator, SA and to all other required agencies within specified timeframes: immediately, but not later than two hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		10/24/24

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F 610	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately implement an intervention to protect 1 of 1 residents (R1) following an allegation of physical staff to resident abuse. This deficient practice had the potential to affect all other residents currently residing in the facility.</p> <p>Findings include:</p> <p>R1's significant changes Minimal Data Set (MDS) dated 6/25/24, indicated R1's diagnoses included dementia and personality disorder. R1's cognition was not impaired.</p> <p>Review of facility report number 358043 submitted to the SA on 9/24/24 at 5:41 p.m. R1 had reported a nursing assistant (NA) while providing cares was angry and telling R1 not to use the call light and it made her angry. R1 reported NA pinched her in the left leg and grabbed her hair with water on her hands. R1 was able to identify the staff as NA-A.</p> <p>Review of NA-A's timecard dated 10/2/24, indicated NA-A had clocked in for work at 5:31 a.m. and clocked out at 3:34 p.m., on the day of the alleged incident 9/24/24.</p> <p>On 10/2/24 at 10:41 a.m., licensed practical nurse (LPN)-B stated following an allegation of staff to resident abuse, the alleged perpetrator would need to be removed from direct care and building pending the investigation to protect the residents.</p> <p>On 10/2/24 at 10:57 a.m., social services (SS)-A stated she was made are of R1's allegation at</p>	F 610	<p>It is the policy of Hopkins Health Services to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. This policy includes the requirement to make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation of suspected abuse. Responses include but are not limited to:</p> <p>A. Responding immediately to protect the alleged victim and integrity of the investigation.</p> <p>B. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.</p> <p>On 10/24/2024 the Facility IDT, Management and staff received education on updated process for handling an identified alleged perpetrator(s) in the event of alleged abuse.</p> <p>If someone receives an allegation of abuse against someone who is on the floor, they are required to approach that individual IMMEDIATELY and escort them to the Administrators office or walk to a phone to call the Administrator together. A written statement should then be obtained from the accused. Once completed the the accused should be IMMEDIATELY escorted to the time clock to punch out and then escorted until they</p>	

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F 610	<p>Continued From page 6</p> <p>approximately 2:00 p.m. on 9/24/24, and SS-A stated the investigation started NA-A had already left the building as her shift was completed. SS-A stated she interviewed R1 regarding the allegation and R1 had reported she now felt safe in the facility knowing NA-A was no longer in the building.</p> <p>On 10/2/24 at 11:14 a.m., administrator stated he was notified of R1's allegation at approximately 2:00 p.m. on 9/24/24. Administrator stated he interviewed R1 at approximately 2:05 p.m., and R1 had reported she did not feel safe in the facility because NA-A was still in the building. Administrator stated he had not interviewed NA-A yet however ensured R1 that NA-A was going to be suspended immediately which R1 then reported she felt safe.</p> <p>On 10/2/24 at 11:31 a.m., LPN-C stated at approximately 11:30 a.m. on 9/24/24, LPN-C was administering R1's medications when R1 reported staff had "pinched" and "hit" her. LPN-C stated NA-A was R1's caregiver that day assisting R1 as needed and requested. LPN-C stated she was not aware of any incidents between R1 and NA-A, and LPN-C stated NA-A appeared fine that day no unusual behaviors.</p> <p>On 10/2/24 at 11:46 a.m., NA-A stated R1 had reported to LPN-C while NA-A was assisting R1 with cares NA-A pinched her. NA-A confirmed she had assisted R1 with cares on the day of the allegation, and NA-A was suspended for three days while the facility completed an investigation, however NA-A could not recall when she left the building on 9/24/24.</p> <p>Review of facility policy titled Abuse, Neglect and</p>	F 610	<p>have left the facility. If the accused has already left the facility, the allegation needs to be reported to the Administrator IMMEDIATELY and the Administrator will contact the accused, received their statement and inform them that they are under suspension and they cannot return to work until an investigation has been completed and they have been informed by the Administrator of the results of the investigation.</p> <p>All future incidents will be reviewed, audited for compliance. These results will be identified in investigations of abuse for 6 months and reviewed at future scheduled QAPI meetings.</p>	

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F 610	Continued From page 7 Exploitation revised 7/15/22, indicated the facility would make efforts to ensure all residents were protected from physical and psychosocial harm during and after the investigation. Examples included but were not limited to responding immediately to protect the alleged victim and integrity of the investigation and room or staffing changes to protect the resident(s) from the alleged perpetrator.	F 610			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2024

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

RE: CCN: 245293
Cycle Start Date: October 2, 2024

Dear Administrator:

On October 2, 2024, a 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.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 January 2, 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 April 2, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Hopkins Health Services

October 15, 2024

Page 3

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) / 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

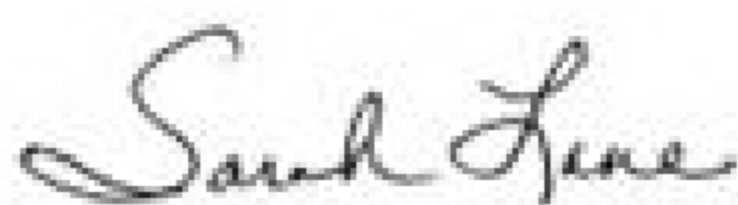
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm

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,



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

October 15, 2024

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

Re: Event ID: 1X9B11

Dear Administrator:

The above facility survey was completed on October 2, 2024 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,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2024
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NAME OF PROVIDER OR SUPPLIER HOPKINS HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343
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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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/1/24 through 10/2/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaint was reviewed during the</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/25/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/02/2024
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NAME OF PROVIDER OR SUPPLIER HOPKINS HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 725 SECOND AVENUE SOUTH HOPKINS, MN 55343
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2 000	<p>Continued From page 1</p> <p>survey: H52938880C (MN00106925).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>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.</p>	2 000		
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