DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

September 3, 2026

Administrator
HAMMER KENTUCKY
18115 30TH AVENUE NORTH
PLYMOUTH, MN 55447

RE: Event ID: 341FB0-H1

Dear Administrator:

On August 20, 2026, an abbreviated 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 Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electronically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). A provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter.

Failure to submit an acceptable written plan of correction for all Health and Life Safety Code Federal deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.

Your PoC must include:

- 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 PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

DEPARTMENT CONTACT:

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

Upon acceptance of your PoC, Life Safety will revisit the facility to verify necessary corrections.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0000 | INITIAL COMMENTS<br><br>On 8/19/26 through 8/20/26, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.<br><br>The following complaints were reviewed.<br><br>HG3003795C (3168634) and<br><br>HG3003825C (3170653)<br><br>with deficiencies issued at W124, W149, W153, W154, W331.<br><br>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. | W0000 | | |
| W0124 | PROTECTION OF CLIENTS RIGHTS<br><br>CFR(s): 483.420(a)(2)<br><br>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to inform the legal guardian of fall for 1 of 1 client (C1) who had a fall with an injury.<br><br>C1's Personal Information Sheet (PIS) undated, indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated staff will be with C1 at all times in | W0124 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0124 | Continued from page 1<br>the community to make sure she doesn't get into any dangerous situations. Staff are aware of C1's vulnerability to abuse and any possible visual signs of abuse and also of possible cues such as "it hurts" and pointing to an area. Staff will communicate any findings, worries, or concerns with C1's team immediately. Staff will also remind C1 to tell staff if she is being hurt.<br><br>C1's Intensive Support Plan (ISP) dated 9/24/25, indicated C1 had seizure disorder that was mostly controlled, has had no fall history, and is not at risk. Staff to monitor for signs and symptoms of illness and injury.<br><br>During interview on 8/20/26 at 9:15 a.m., program manager (PM) stated C1 had a fall when walking to go onto the bus on 7/01/26. PM stated he did not fill out an incident report due to direct support professional (DSP)-C stated she attempted to break the fall, so the PM stated he did not feel it was an actual fall. PM stated the incident occurred due to the cement outside was lower going to the sidewalk so they had the cement slab raised so this would not happen again.<br><br>A communication notes from C1's day program dated 7/01/26, indicated C1 arrived at the day program with her right knee bleeding and C1 stated she had fallen at the facility and in the bus prior to arriving at the day program.<br><br>During interview on 8/20/26 at 9:30 a.m., PM stated he was not aware of the note of C1 falling on the bus. PM stated he thought he informed the guardian of the fall but when looking through his email, stated he informed the case manager and not the legal guardian.<br><br>During interview on 8/20/26 at 11:20 a.m., the house registered nurse (RN)-A stated PM should have notified the guardian of the fall, and an incident report should have been completed to track C1's falls. RN-A further indicated PM should have called the bus company to gather more information regarding C1's fall on the bus to see if there was an injury and to receive details of that fall to complete an additional incident report.<br><br>Incident Response, Reporting and Review Policy revised 1/01/2014, indicated incident reports will be completed as soon possible after the occurrence, but no later than 24 hours after the incident occurred the written report will include the name of the person involved in the incident, the date, time and location of the incident, a description of the | W0124 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0124 | Continued from page 2<br>incident and a description of the response to the incident and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable. In addition, to notification to the person's legal representative or designated emergency contact and case manager. | W0124 | | |
| W0149 | STAFF TREATMENT OF CLIENTS<br><br>CFR(s): 483.420(d)(1)<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to follow the facility abuse policy in immediately reporting and investigating 1 of 1 client (C1) who had injuries of unknown origin,<br><br>C1's Personal Information Sheet (PIS) undated, indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated staff will be with C1 at all times in the community to make sure she doesn't get into any dangerous situations. Staff are aware of C1's vulnerability to abuse and any possible visual signs of abuse and also of possible cues such as "it hurts" and pointing to an area. Staff will communicate any findings, worries, or concerns with C1's team immediately. Staff will also remind C1 to tell staff if she is being hurt.<br><br>C1's Medication listing dated 8/19/26, indicated C1 received Jardiance 10 milligrams (mg) one tablet by mouth once daily started on 7/27/26, to treat type 2 diabetes. C1 also started on Furosemide 5mg every morning (diuretic) on 7/27/26 and had a rare side effect that could cause low blood count and bruising.<br><br>During interview on 8/20/26 at 9:15 a.m., program manager (PM) stated he noticed on 8/14/26, C1 had purple marks on her arms, legs, and back. PM stated C1's day program also sent pictures to him of the marks and did not feel they were bruises or injuries because C1 had recently started on new medications. In addition, PM stated no one would ever hurt C1, so a report was not made to the state agency (SA) and an investigation was not completed. | W0149 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0149 | Continued from page 3<br>During interview on 8/20/26 at 10:24 a.m., physician assistant (PA)-C stated C1 had a new diagnosis of congestive heart failure, been declining, and seen on 8/17/26, in the morning. PA-C stated she was notified by the staff of the bruising on 8/14/26, by the portal. She noticed bruising on her arms and legs and was not sure the cause. PA-C visit note indicated there was a chance the bruising was from the Furosemide which was just started. PA-C had ordered labs to have C1's platelets and hemoglobin checked to see if the medication could have caused the bruises but had not received the results and she later that day went to the hospital.<br><br>During interview on 8/20/26 at 11:12 a.m., C1's guardian (G) stated C1 was hospitalized on 8/17/26, later in the morning after she was sent to day program due to increased pain and low oxygen saturation levels. G stated she was informed by the hospital C1 had multiple bruises on her arms and legs and they had concerns and did not want C1 to return home until they had a safe plan in place until they discharged her.<br><br>During interview on 8/20/26 at 11:30 a.m., house registered nurse (RN)-A stated she noticed C1's bruising on 8/14/26. C1 had declined in her condition and required assistance of two with transfers and a wheelchair for mobility. RN-A stated she reported the bruising on the portal to PA-C. PM would be the staff member to report to the SA and complete an investigation. RN-A stated she was unaware what had caused the bruising and documented them on her skin assessment on 8/14/26.<br><br>During interview on 8/20/26 at 2:09 p.m., direct support professional (DSP)-A stated C1 had declined in her mobility and for transfers she had required assist of two for the last week to get her out of bed. They do not have a Hoyer lift so one staff member would have to lift under her arms and another staff would hold her legs up while they would place C1 into a wheelchair. DSP-A stated he did not think the transfers caused the bruising and PM told him it was her medication.<br><br>During interview on 8/20/26 at 2:28 p.m., registered nurse (RN)-B caring for C1 at the hospital, stated C1 had bruising on both of her outer arms and legs when she admitted on 8/17/26. They are going away and looked like fingerprints on her outer arms. RN-B stated labs were drawn when she was admitted and her Hemoglobin was 10.8 grams per deciliter g/dl (normal is 12) and Platelets were 345,000 (150,000 to 450,000 platelets per microliter of blood) which was | W0149 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0149 | Continued from page 4<br>normal. RN-B stated with lab levels in this range he felt that would not be the cause of her bruising.<br><br>Mistreatment of Vulnerable Adults Reporting Policy revised 10/31/2010, indicated it is policy to protect the adults we serve who are vulnerable to mistreatment and to require the reporting of suspected mistreatment of vulnerable adults. As a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated, you must report it immediately. A mandated report or administrator will contact MAARC immediately. Immediately means as soon as possible from the time that the initial knowledge of the incident has occurred. Within 24 hours or as soon as possible, the investigator will complete a collection of all interviews, statements, physical evidence, review of CSSP and any pertinent maps, pictures or diagrams. | W0149 | | |
| W0153 | STAFF TREATMENT OF CLIENTS<br><br>CFR(s): 483.420(d)(2)<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and document review the facility failed to immediately report an injury of unknown origin for 1 of 1 client (C1) who had multiple bruises.<br><br>C1's Personal Information Sheet (PIS) undated, indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated staff will be with C1 at all times in the community to make sure she doesn't get into any dangerous situations. Staff are aware of C1's vulnerability to abuse and any possible visual signs of abuse and also of possible cues such as "it hurts" and pointing to an area. Staff will communicate any findings, worries or concerns with C1's team immediately. Staff will also remind C1 to tell staff if she is being hurt.<br><br>C1's Medication listing dated 8/19/26, indicated C1 received Jardiance 10 milligrams (mg) one tablet by mouth once daily started on 7/27/26, to treat type 2 diabetes. C1 also started on Furosemide 5mg every morning (diuretic) on 7/27/26 and had a rare side effect that could cause low blood count and | W0153 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0153 | Continued from page 5<br>bruising.<br><br>During interview on 8/20/26 at 9:15 a.m., program manager (PM) stated he noticed on 8/14/26, C1 did have purple marks on her arms, legs and back. PM stated C1's day program also sent pictures to him of the marks and did not feel they were bruises or injuries because C1 had recently started on new medications. In addition, PM stated no one would ever hurt C1, so a report was not made to the state agency (SA).<br><br>During interview on 8/20/26 at 10:24 a.m., physician assistant (PA)-C stated C1 had a new diagnosis of congestive heart failure, had been declining, and seen on 8/17/26, in the morning. PA-C stated she was notified by the staff of the bruising on 8/14/26, by the portal. She noticed bruising on her arms and legs and was not sure the cause. PA-C indicated in her visit note there was a chance it could have been from the Furosemide which was just started. PA-C ordered labs to have C1's platelets and hemoglobin checked to see if the medication could have caused the bruises easier but had not received the results and C1 had gone to the hospital that same day.<br><br>During interview on 8/20/26 at 11:12 a.m., C1's guardian (G) stated C1 was hospitalized on 8/17/26, later in the morning after she was sent to day program due to increased pain and low oxygen saturation levels. G stated she was informed by the hospital C1 had multiple bruises on her arms and legs. They had concerns and did not want C1 to return home until they had a safe plan in place.<br><br>During interview on 8/20/26 at 11:30 a.m., house registered nurse (RN)-A stated she noticed C1's bruising on 8/14/26. C1 had declined in her condition and required assistance of two with transfers and a wheelchair for mobility. RN-A stated she reported the bruising on the portal to PA-C. PM would be the staff member to report to the SA and complete an investigation. RN-A stated she was unaware what had caused the bruising and documented them on her skin assessment on 8/14/26.<br><br>During interview on 8/20/26 at 2:09 p.m., direct support professional (DSP)-A stated C1 had declined in her mobility. C1 had required assist of two for the last week for transfers and to get her out of bed. They do not have a Hoyer lift so one staff member would have to lift under her arms and another staff would hold her legs up while they would place C1 into a wheelchair. DSP-A stated he did not think the transfers caused the bruising and PM told him it was | W0153 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0153 | Continued from page 6<br>C1's medication.<br><br>During interview on 8/20/26 at 2:28 p.m., registered nurse (RN)-B caring for C1 at the hospital, stated C1 had bruising on both of her outer arms and legs when she admitted on 8/17/26. They were going away but looked like fingerprints on her outer arms. RN-B stated labs were drawn when she was admitted. C1's Hemoglobin was 10.8 grams per deciliter g/dl (normal is 12) and Platelets were 345,000 (150,000 to 450,000 platelets per microliter of blood) which was normal. RN-B stated with lab levels in this range he felt that would not be the cause of her bruising.<br><br>Mistreatment of Vulnerable Adults Reporting Policy revised 10/31/2010, indicated it is policy to protect the adults we serve who are vulnerable to mistreatment and to require the reporting of suspected mistreatment of vulnerable adults. As a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated, you must report it immediately. A mandated report or administrator will contact the MAARC immediately. Immediately means as soon as possible from the time that the initial knowledge of the incident has occurred. | W0153 | | |
| W0154 | STAFF TREATMENT OF CLIENTS<br><br>CFR(s): 483.420(d)(3)<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 client (C1) who had bruising on her arms, legs and back.<br><br>C1's Personal Information Sheet (PIS) undated, indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated staff will be with C1 at all times in the community to make sure she doesn't get into any dangerous situations. Staff are aware of C1's vulnerability to abuse and any possible visual signs of abuse and also of possible cues such as "it hurts" and pointing to an area. Staff will communicate any findings, worries or concerns with C1's team immediately. Staff will also remind C1 to tell staff if she is being hurt. | W0154 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0154 | Continued from page 7<br><br>C1's Medication listing dated 8/19/26, indicated C1 received Jardiance 10 milligrams (mg) one tablet by mouth once daily started on 7/27/26, to treat type 2 diabetes. C1 also started on Furosemide 5mg every morning (diuretic) on 7/27/26 and had a rare side effect that could cause low blood count and bruising.<br><br>During interview on 8/20/26 at 9:15 a.m., program manager (PM) stated he noticed on 8/14/26, C1 did have purple marks on her arms, legs and back. PM stated C1's day program also sent pictures to him of the marks and did not feel they were bruises or injuries because C1 had recently started on new medications. In addition, PM stated no one would ever hurt C1. PM did not complete an internal investigation of the marks on C1.<br><br>During interview on 8/20/26 at 10:24 a.m., physician assistant (PA)-C stated C1 had a new diagnosis of congestive heart failure, C1 had been declining and PA-C saw C1 on 8/17/26, in the morning. PA-C stated she was notified by the staff of the bruising on 8/14/26, by the portal. PA-C noticed bruising on C1's arms and legs and was not sure the cause. PA-C did mention in her visit note there was a chance it could have been from her Furosemide which C1 just started. PA-C ordered labs to have 1's platelets and hemoglobin checked to determine if the medication could have caused her to bruise easier. Lab results were not received prior to this interview.<br><br>During interview on 8/20/26 at 11:12 a.m., C1's guardian (G) stated C1 was hospitalized on 8/17/26, later in the morning after she was sent to day program due to increased pain and low oxygen saturation levels. The G stated she was informed by the hospital C1 had multiple bruises on her arms and legs and they had concerns. The hospital did not want C1 to return home until there was a safe plan in place.<br><br>During interview on 8/20/26 at 11:30 a.m., house registered nurse (RN)-A stated she noticed C1's bruising on 8/14/26. C1 had declined in her condition and required assistance of two with transfers and a wheelchair for mobility. RN-A stated she reported the bruising on the portal to PA-C and the PM would be the staff member to complete an investigation. RN-A stated she was unaware what had caused the bruising and documented them on C1's skin assessment on 8/14/26.<br><br>During interview on 8/20/26 at 2:09 p.m., direct | W0154 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0154 | Continued from page 8<br>support professional (DSP)-A stated C1 had declined in her mobility and for transfers. C1 required assist of two for the last week to get her out of bed. The facility did not have a Hoyer lift (full body mechanical lift) so one staff member would have to lift under C1's arms and another staff would hold her legs up to transfer C1 into a wheelchair. DSP-A stated he did not think the transfers caused the bruising and the PM told DSP-A it was C1's medication.<br><br>During interview on 8/20/26 at 2:28 p.m., the hospital RN-B caring for C1 at the hospital, stated C1 had bruising on both of her outer arms and legs when she admitted on 8/17/26. The bruises were healing and looked like fingerprints on her outer arms. RN-B stated labs were drawn when C1 was admitted and her Hemoglobin was 10.8 grams per deciliter g/dl (normal is 12) and Platelets were 345,000 (150,000 to 450,000 platelets per microliter of blood) which was normal. RN-B stated with lab levels in this range he felt that would not be the cause of her bruising.<br><br>Mistreatment of Vulnerable Adults Reporting Policy revised 10/31/2010, indicated it is policy to protect the adults we serve who are vulnerable to mistreatment and to require the reporting of suspected mistreatment of vulnerable adults. Pending initial investigation, the investigator will determine if there is a need for temporary or permanent removal of the accused perpetrator from the site. The removal of accused perpetrator will be determined by findings from the initial investigation, the risk of further harm from the perpetrator or the likelihood that the accused perpetrator will be unsupervised with the individual Resolution of any discrepancies; Recommendations for action both to safeguard all the individuals during the investigations and after the completion of the report. | W0154 | | |
| W0331 | NURSING SERVICES<br><br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to follow nursing practices for 1 of 1 client (C1) reviewed for notification of fall to provider and follow through with therapy referral.<br><br>C1's Personal Information Sheet (PIS) undated, | W0331 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0331 | Continued from page 9<br>indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Intensive Support Service Assessment dated 9/24/25, indicated C1 was not at risk for falls.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated C1 had the inability to identify dangerous situations and staff would be with C1 to make sure C1 would not be in a dangerous situation and to report if anything would happen to C1.<br><br>During interview on 8/20/26 at 10:24 a.m., physician assistant (PA)-C stated C1 had a new diagnosis of congestive heart failure and had been declining. PA-C saw C1 on 8/17/26, in the morning. PA-C stated on 8/14/26, C1 was already declining and she had written a referral for C1 to be evaluated by physical and occupational therapy (PT/OT) at the home. PA-C noticed on 8/17/26, the referral was never followed through. The PA-C stated she was not notified of C1's fall at the home or on the bus going to day program and should had been when it happened on 7/01/26.<br><br>During interview on 8/20/26 at 11:30 a.m., house registered nurse (RN)-A stated she was unaware there was a referral for C1 to be seen by PT/OT on 8/14/26 and another referral was made by the PA-C on 8/17/26. RN-A stated the facility needed to have better communication on who needed to make follow-up referrals. In addition, RN-A stated C1's bruises should have been reported to the state agency (SA) and investigated since they were injuries of unknown origin. RN-A stated if C1 had been seen by therapy they might have prevented the bruising after finding out C1 needed more assistance with transfers.<br><br>During interview on 8/20/26 at 12:43 p.m., program manager (PM) stated he thought the lead medical direct support professional (DSP)-M had taken care of the referral before he left on vacation a couple of weeks ago. The PM stated DSP-M was out of the country, and he would not be able to contact him.<br><br>During interview on 8/20/26 at 1:00 p.m., call was placed to therapy company the referral was placed to and receptionist/scheduler stated they had never received a referral by fax, email or phone call for C1.<br><br>Call was placed to the program director (PD) on 8/20/26 at 1:20 p.m., with no return call. Received return call on 8/24/26 at 4:30 p.m., with a planned scheduled meeting on 8/25/26 at 4:30 p.m. Attempted to call the PD on 8/25/26 at 4:10 p.m., to | W0331 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G300 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| W0331 | Continued from page 10<br>verify the meeting with no answer. Called the PD on 8/25/26 at the scheduled meeting time of 4:30 p.m., and the call went straight to voicemail. An email was sent on 8/25/26, requesting information on the 7/01/26 fall, reporting of the fall to guardians and reporting injuries of unknown origin with no response as of 8/27/26.<br><br>Care Specific Illness and Injury Policy and Procedure revised 11/2024, indicated for falls examine injured area, treat as accordingly, move to a comfortable area, if there is an indication of fracture or sprain refer to sections on fracture or sprains. Complete an Incident Report Form.<br><br>Incident Response, Reporting and Review Policy revised on 1/01/24, indicated incident reports will be completed as soon as possible after the occurrence, but no later than 24 hours after the incident occurred. All incidents must be reported to the person's legal representative or designated emergency contact and case manager. | W0331 | | |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

September 3, 2026

Administrator
HAMMER KENTUCKY
18115 30TH AVENUE NORTH
PLYMOUTH, MN 55447

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: **341FB0-H1**

Dear Administrator:

The above facility was surveyed on August 20, 2026 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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 of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Supervised Living Facilities.

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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

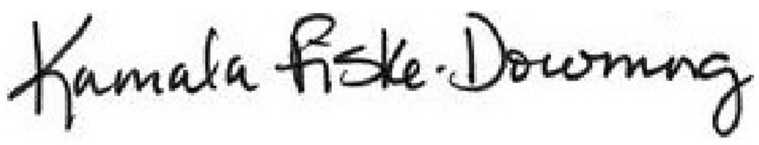
The first page of the state orders should be signed and submitted to:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 the supervisor listed above. A written plan for correction of licensing orders is not required.

Feel free to contact me with any questions related to this letter.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
**Minnesota Department of Health**
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01581 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| 50000 | Initial Comments<br><br>In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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.<br><br>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 or MN Statute indicated below. When a rule or statute 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.<br><br>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.<br><br>On 8/19/26 to 8/20/26, a standard abbreviated survey was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).<br><br>The following complaints were reviewed.<br><br>HG3003795C (3168634)<br><br>HG3003825C (3170653)<br><br>with licensing orders issued at order 0380 and 0815.<br><br>When corrections are completed, please sign and date, make a copy of these orders and electronically return to: | 50000 | | |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01581 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| 50000 | Continued from page 1<br>Nikki.harvey@state.mn.us | 50000 | | |
| 50380 | PURPOSE OF HEALTH SERVICES.<br><br>CFR(s): MN Rule 4665.3300<br><br>Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to follow nursing practices for 1 of 1 client (C1) reviewed for notification of fall to provider and follow through with therapy referral.<br><br>C1's Personal Information Sheet (PIS) undated, indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Intensive Support Service Assessment dated 9/24/25, indicated C1 was not at risk for falls.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated C1 had the inability to identify dangerous situations and staff would be with C1 to make sure C1 would not be in a dangerous situation and to report if anything would happen to C1.<br><br>During interview on 8/20/26 at 10:24 a.m., physician assistant (PA)-C stated C1 had a new diagnosis of congestive heart failure and had been declining. PA-C saw C1 on 8/17/26, in the morning. PA-C stated on 8/14/26, C1 was already declining and she had written a referral for C1 to be evaluated by physical and occupational therapy (PT/OT) at the home. PA-C noticed on 8/17/26, the referral was never followed through. The PA-C stated she was not notified of C1's fall at the home or on the bus going to day program and should had been when it happened on 7/01/26.<br><br>During interview on 8/20/26 at 11:30 a.m., house registered nurse (RN)-A stated she was unaware there was a referral for C1 to be seen by PT/OT on 8/14/26 and another referral was made by the PA-C on 8/17/26. RN-A stated the facility needed to have better communication on who needed to make follow-up referrals. In addition, RN-A stated C1's bruises should have been reported to the state agency (SA) and investigated since they were injuries of unknown origin. RN-A stated if C1 had been seen by therapy they might have prevented the | 50380 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01581 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| 50380 | Continued from page 2<br>bruising after finding out C1 needed more assistance with transfers.<br><br>During interview on 8/20/26 at 12:43 p.m., program manager (PM) stated he thought the lead medical direct support professional (DSP)-M had taken care of the referral before he left on vacation a couple of weeks ago. The PM stated DSP-M was out of the country, and he would not be able to contact him.<br><br>During interview on 8/20/26 at 1:00 p.m., call was placed to therapy company the referral was placed to and receptionist/scheduler stated they had never received a referral by fax, email or phone call for C1.<br><br>Call was placed to the program director (PD) on 8/20/26 at 1:20 p.m., with no return call. Received return call on 8/24/26 at 4:30 p.m., with a planned scheduled meeting on 8/25/26 at 4:30 p.m. Attempted to call the PD on 8/25/26 at 4:10 p.m., to verify the meeting with no answer. Called the PD on 8/25/26 at the scheduled meeting time of 4:30 p.m., and the call went straight to voicemail. An email was sent on 8/25/26, requesting information on the 7/01/26 fall, reporting of the fall to guardians and reporting injuries of unknown origin with no response as of 8/27/26.<br><br>Care Specific Illness and Injury Policy and Procedure revised 11/2024, indicated for falls examine injured area, treat as accordingly, move to a comfortable area, if there is an indication of fracture or sprain refer to sections on fracture or sprains. Complete an Incident Report Form.<br><br>Incident Response, Reporting and Review Policy revised on 1/01/24, indicated incident reports will be completed as soon as possible after the occurrence, but no later than 24 hours after the incident occurred. All incidents must be reported to the person's legal representative or designated emergency contact and case manager.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 50380 | | |
| 50815 | VA Timing of report.<br><br>CFR(s): MN Statute 626.557 Subd. 3.<br><br>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an | 50815 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01581 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| 50815 | Continued from page 3<br>individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:<br><br>(1) the individual was admitted to the facility from another facility and the reporter has<br><br>reason to believe the vulnerable adult was maltreated in the previous facility; or<br><br>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as<br><br>defined in section 626.5572, subdivision 21, clause (4).<br><br>(b) A person not required to report under the provisions of this section may voluntarily<br><br>report as described above.<br><br>(c) Nothing in this section requires a report of known or suspected maltreatment, if the<br><br>reporter knows or has reason to know that a report has been made to the common entry point.<br><br>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement<br><br>agency.<br><br>(e) A mandated reporter who knows or has reason to believe that an error under section<br><br>626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this<br><br>subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by: | 50815 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01581 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| 50815 | Continued from page 4<br>Based on interview and document review the facility failed to immediately report an injury of unknown origin for 1 of 1 client (C1) who had multiple bruises.<br><br>C1's Personal Information Sheet (PIS) undated, indicated C1 had severe intellectual disabilities and seizure disorder.<br><br>C1's Individual Abuse Prevention Plan (IAPP) dated 9/24/25, indicated staff will be with C1 at all times in the community to make sure she doesn't get into any dangerous situations. Staff are aware of C1's vulnerability to abuse and any possible visual signs of abuse and also of possible cues such as "it hurts" and pointing to an area. Staff will communicate any findings, worries or concerns with C1's team immediately. Staff will also remind C1 to tell staff if she is being hurt.<br><br>C1's Medication listing dated 8/19/26, indicated C1 received Jardiance 10 milligrams (mg) one tablet by mouth once daily started on 7/27/26, to treat type 2 diabetes. C1 also started on Furosemide 5mg every morning (diuretic) on 7/27/26 and had a rare side effect that could cause low blood count and bruising.<br><br>During interview on 8/20/26 at 9:15 a.m., program manager (PM) stated he noticed on 8/14/26, C1 did have purple marks on her arms, legs and back. PM stated C1's day program also sent pictures to him of the marks and did not feel they were bruises or injuries because C1 had recently started on new medications. In addition, PM stated no one would ever hurt C1, so a report was not made to the state agency (SA).<br><br>During interview on 8/20/26 at 10:24 a.m., physician assistant (PA)-C stated C1 had a new diagnosis of congestive heart failure, had been declining, and seen on 8/17/26, in the morning. PA-C stated she was notified by the staff of the bruising on 8/14/26, by the portal. She noticed bruising on her arms and legs and was not sure the cause. PA-C indicated in her visit note there was a chance it could have been from the Furosemide which was just started. PA-C ordered labs to have C1's platelets and hemoglobin checked to see if the medication could have caused the bruises easier but had not received the results and C1 had gone to the hospital that same day.<br><br>During interview on 8/20/26 at 11:12 a.m., C1's guardian (G) stated C1 was hospitalized on 8/17/26, later in the morning after she was sent to day program due to increased pain and low oxygen saturation levels. G stated she was informed by the | 50815 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01581 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMER KENTUCKY | 18115 30TH AVENUE NORTH , PLYMOUTH, Minnesota, 55447 |

| (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 |
|---|---|---|---|---|
| 50815 | Continued from page 5<br>hospital C1 had multiple bruises on her arms and legs. They had concerns and did not want C1 to return home until they had a safe plan in place.<br><br>During interview on 8/20/26 at 11:30 a.m., house registered nurse (RN)-A stated she noticed C1's bruising on 8/14/26. C1 had declined in her condition and required assistance of two with transfers and a wheelchair for mobility. RN-A stated she reported the bruising on the portal to PA-C. PM would be the staff member to report to the SA and complete an investigation. RN-A stated she was unaware what had caused the bruising and documented them on her skin assessment on 8/14/26.<br><br>During interview on 8/20/26 at 2:09 p.m., direct support professional (DSP)-A stated C1 had declined in her mobility. C1 had required assist of two for the last week for transfers and to get her out of bed. They do not have a Hoyer lift so one staff member would have to lift under her arms and another staff would hold her legs up while they would place C1 into a wheelchair. DSP-A stated he did not think the transfers caused the bruising and PM told him it was C1's medication.<br><br>During interview on 8/20/26 at 2:28 p.m., registered nurse (RN)-B caring for C1 at the hospital, stated C1 had bruising on both of her outer arms and legs when she admitted on 8/17/26. They were going away but looked like fingerprints on her outer arms. RN-B stated labs were drawn when she was admitted. C1's Hemoglobin was 10.8 grams per deciliter g/dl (normal is 12) and Platelets were 345,000 (150,000 to 450,000 platelets per microliter of blood) which was normal. RN-B stated with lab levels in this range he felt that would not be the cause of her bruising.<br><br>Mistreatment of Vulnerable Adults Reporting Policy revised 10/31/2010, indicated it is policy to protect the adults we serve who are vulnerable to mistreatment and to require the reporting of suspected mistreatment of vulnerable adults. As a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated, you must report it immediately. A mandated report or administrator will contact the MAARC immediately. Immediately means as soon as possible from the time that the initial knowledge of the incident has occurred. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 50815 | | |