Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 7, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: Reinspection Results
Event ID: 2J7812

Dear Administrator:

On October 4, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 23, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: August 23, 2023

Dear Administrator:

On August 23, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 November 23, 2023 (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 February 23, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/21/23 through 8/23/23 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		9/25/23

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

Electronically Signed | 09/25/2023

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 at 10:30 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	E 041	It is the practice of GlenOaks Senior Living Campus to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition) Health Cre facilities Code, section 6.4.4.1.1.4, and NFPA 110(2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. CORRECTIVE ACTION: The Maintenance Director has implemented generator and transfer switches testing, inspection and maintenance in accordance with the required standards and will use the proper weekly and monthly generator forms to document the findings and outcomes. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Interstate Power Systems has been contacted and scheduled for October 4th, 2023 to do the 4 hour load bank test. Scheduled test under load conditions includes a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established	

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E 041	Continued From page 4	E 041	according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. MEASURES TO PREVENT REOCCURENCE: Clipboards have been created with the proper forms and placed in the maintenance office to document the generator testing and inspection per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. The Maintenance Director will utilize the TELS software program to schedule and create reminders of the required testing and inspections. MONITORING/AUDITING: The Maintenance Director and Administrator will review compliance on a weekly basis for 3 months, then monthly thereafter. The Maintenance Director is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future monitoring and training. ACTUAL/PROPOSED DATE OF REMEDY: The facility alleges that it will be in	

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E 041	Continued From page 5	E 041	substantial compliance and complete all action items by October 4th, 2023	
F 000	INITIAL COMMENTS On 8/21/23 through 8/23/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: MN94886/H53604631C MN88127/H53604635C MN86353/H53604636C MN87886/H53604637C MN87909/H53604638C The following complaints were reviewed with deficiencies cited: MN90935/H53604634C 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 substantial compliance with the regulations has been attained.	F 000		
F 552 SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.	F 552		9/26/23

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F 552	Continued From page 6 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain informed consent including risks and benefits for 4 out of 4 residents (R13, R20, R21, and R37) reviewed for use of psychotropic medications. Findings include: R13's admission Minimum Data Set (MDS) dated 6/26/23, indicated severe cognitive impairment with no evidence of hallucinations and delusions. He has the following: diagnoses of schizophrenia, major depressive disorder, anxiety disorder, and obsessive-compulsive disorder. R13's physician's orders indicated the following psychotropic medication orders: Celexa dated 6/22/23 (an antidepressant), and risperidone dated 6/22/23 (an antipsychotic). However, the	F 552	F552: Psychotropic Consents were obtained for R13, R20, R21, and R37. Audits were completed on all resident□s taking psychotropic medications and consents obtained to give medications as well as education on risks vs benefits of taking medications. Policies and Procedures reviewed with no changes. Training on when a resident starts a psychotropic medication that consent as well as education on risks vs benefits needs to be completed. Audits to be completed by DON/Designee weekly X 4 weeks, then monthly X 3 months with results reviewed by QAA Committee.	

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F 552	Continued From page 7 record lacked evidence of Informed consents regarding risk versus benefit of these medications. R20's admission MDS dated 6/15/23, indicated severe cognitive impairment, evidence of hallucinations and delusions and diagnoses of major depressive disorder, dementia without behavioral disturbance and cerebral vascular disease. R20's physician's orders indicated the following psychotropic medication orders: duloxetine dated 6/15/23, trazodone dated 6/15/23, nortriptyline dated 6/29/23 (all antidepressants), and quetiapine dated 6/15/23 (an antipsychotic). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. R21's quarterly MDS dated 7/10/23, indicated no cognitive impairment, hallucinations or delusions. He does have the following diagnoses: adjustment disorder with depressed mood, mild cognitive impairment of uncertain or unknown etiology, and anxiety disorder. R21's physician's orders indicate the following psychotropic medication orders: buspirone HCL dated 5/25/23 (an anxiolytic) , seroquel dated 5/8/23 (an antipsychotic), and Cymbalta dated 5/8/23 (an antidepressant). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. R37's admission MDS dated 7/21/23, indicated moderately impaired cognition and diagnoses of vascular dementia, cerebral vascular disease, major depressive disorder, and history of	F 552		

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F 552	Continued From page 8 traumatic brain injury. R37's physician's orders indicated the following psychotropic medication orders: Sertraline dated 8/20/23 (an antidepressant), and olanzapine dated 8/20/23 (an antipsychotic). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. On 8/23/23 at 1:20 p.m., the director of clinical services (DOCS) and licensed practical nurse (LPN-C) confirmed the facility failed to obtain informed consents including risk and benefit discussions of all psychotropic medications used by all 4 residents. The facility policy Psychotropic Medications dated 11/28/21, identified "The resident and/or resident representative will be informed prior to the initiation of psychotropic medication."	F 552		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident was comprehensively assessed for self-administration of medications for 3 of 3 residents (R8, R17, and R29), observed for self-administration of medications. Findings include:	F 554	F554: Comprehensive self-administration of medication assessments completed on R8, R17, and R29. All residents reviewed and comprehensive self-administration of medication assessments completed on all resident who self-administer medications. Education provided to nurses on	9/26/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 9 R8's quarterly MDS dated 6/9/23, identified R8 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's). Review of R8's medication record lacked evidence of R8 being assessed for self-administration of medications. During observation and interview on 8/21/23 at 2:05 p.m., a tube of medicated gel was on the nightstand next to R8's recliner. R8 confirmed she had medicated gel on her nightstand and used it when needed on her shoulders, back and knees. During observation on 8/22/23 at 3:27 p.m., the tube of medicated gel remained on nightstand. R8's electronic health record (EHR) indicated "May NOT self-administer meds". During interview on 8/23/23 at 2:39 p.m., nursing assistant (NA)-B stated she had seen R8 apply the medicated gel to her knees, shoulder blades and/or lower back. NA-B stated R8 occasionally asked staff to apply it for her, but R8 normally applied it on her own. R17's quarterly MDS dated 8/3/23, indentified cognitively intact and required supervision with walking in corridor, locomotion off unit, eating, personal hygiene, and bathing. During an interview on 8/21/23 at 1:48 p.m., R17 stated concerns about her missing albuterol inhaler. She stated there was a new box on the med cart, but it was empty. R17 had a red inhaler	F 554	completing the self-administration of medication assessment with any resident requesting to self-administer medications as well as obtaining MD orders and update the residents plan of care. Policies and Procedures reviewed without changes. Audits to be completed by DON/Designee for all resident□s that self-administer medications weekly X 4 week then monthly X 3 months with results reviewed by QAA Committee.	

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	245360	A. BUILDING _____ B. WING _____	C 08/23/2023

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F 554	Continued From page 10 sitting on her side table and stated she only had enough doses for a few more days and needed to talk to LPN-B. On 8/22/23 at 9:51 a.m., R17 was at a table in the dining/common room conversing with another resident. A red inhaler was on the table next to eye glasses and a cellphone. At 10:10 a.m., R17 stood up, put the red inhaler in her front pants pocket and walked away. Interview on 8/22/23 at 10:23 a.m., Licensed Practical Nurse (LPN)-A stated the empty box in the med cart was for the inhaler R17 currently had in her possession. LPN-A stated it looked like another refill had already been ordered from the pharmacy. LPN-A confirmed R17's record lacked evidence of a SAM assessment and order. LPN-A stated the inhaler was one of R17's possessions that helped to keep her calm and she did not use it often. It still had 103 puffs remaining. R29's significant change MDS dated 5/16/23, identified R29 was moderately impaired, and required assistance/supervision with activities of daily living (ADL's). Review of R29's medication record lacked evidence of a SAM assessment and order. During observation on 8/21/23 at 1:57 p.m., registered nurse (RN)-C went into R29's room and set up a nebulizer machine and placed a mask on R29's face. The machine was turned on and and RN-C left R29's room while the nebulizer was running. During observation on 8/22/23 at 3:14 p.m., R29 was sitting alone in their room. The nebulizer	F 554		

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F 554	Continued From page 11 mask was on R29's face and the machine was running. R29 was sleeping, head hanging down making the lower part of the mask not fitted on face allowing solution to go out the bottom. At 3:21 p.m., nursing assistant went into R29's room, shut off nebulizer machine and removed mask. During interview on 8/22/23 at 3:36 p.m., licensed practical nurse (LPN)-B confirmed R8 and R29 did not have a SAM assessment and order. During interview on 8/23/23 at 2:39 p.m., NA-B stated R29 was not able to take nebulizer mask off by himself and the NAs' removed the mask after the treatment was completed. Interview on 8/23/23 at 3:50 p.m., registered nurse (RN)-B stated Self Administration Medication Assessment (SAMA) were completed when a resident requested to self-administer a medication. The results of the assessment were communicated with the care team via fax. They then get a fax back with the providers recommendations and/or order for self-administration. RN-B's expected an assessment would have been completed before the resident was allowed to self-administer the medication. RN-B stated she worked in the unit recently, and noticed the resident had her inhaler. R17 stated she was using it herself for a very long time and became upset with RN-B when she needed to observe her use of it and take her oral medications. RN-B stated she should have followed up in this at that time, but she did not. RN-B stated they should also monitor the use of the inhaler to ensure it was used appropriately. During interview on 8/23/23 at 3:21 p.m.,	F 554		

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F 554	Continued From page 12 assistant director of nursing (ADON) stated in order for a resident to be able to self-administer medications, a self-administration assessment must be completed. Assessments were completed by any nurse. If the resident was determined to be able to self-administer medications, the nurse notified the provider to obtain an order. ADON stated it was important for a resident to be assessed to ensure they received the correct medication and dose. The Self-Administration of Medications policy dated 2016, indicated that the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the residents: a. Ability to read and understand medication labels. b. Comprehension of the purpose and proper dosage and administration time for his or her medications. c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. 3. If the team determines that a resident cannot safely self-administer medications, the nursing	F 554		

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F 554	Continued From page 13 staff will administer the resident's medications. 4. The staff and practitioner will ask residents who are identified as being able to self-administer medications whether they wish to do so. 5. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. 6. For self-administering resident, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. 9. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party. 13. The staff and practitioner will periodically reevaluate a resident's ability to continue to self-administer medications.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		9/26/23

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F 578	Continued From page 14 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the resident's medical record to ensure resident's wishes would be implemented correctly in an emergency for 1 of	F 578	F578: Code status reviewed for R25. Code Status updated to match in R25□s orders, chart, and care plan. All residents code status reviewed to ensure that they are current and match in their orders, chart, and care plan. Training on why	

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F 578	Continued From page 15 14 residents (R25) reviewed for advanced directives. Findings Include: R25's quarterly Minimum Data Set (MDS) dated 5/10/23, identified moderate cognitive impairment and diagnoses which included: type 2 diabetes mellitus, essential hypertension, Parkinson's disease, and stage 4 chronic kidney disease. R25's MDS further identified R25 required extensive assistance from staff for all activities of daily living (ADL's). R25's care plan revised 8/9/23, identified R25's advance directives were DNR (do not resuscitate). R25's electronic medical record (EMR) identified the following: -R25's Order Summary Report identified Advance Directive: DNR -R25's dashboard Profile (viewed on computer screen) identified Advance Directive: DNR. R25's paper chart identified the following: -R25's Provider Orders for Life-Sustaining Treatment (POLST) Form signed 2/15/23, identified FULL CODE - Resident and/or legal representative DOES want resident to be resuscitated. This resident is considered a "FULL CODE" status. During an interview on 8/22/23, at 10:45 a.m., R25's daughter stated R25 has answered his code status wishes in different ways in the past year. R25's daughter stated that she knows what it says on paper but that R25 will answer if differently when asked.	F 578	code status needs to be consistent in all three places to ensure emergency care and treatments are implemented accurately. Policies and Procedures reviewed without changes. Audits to be completed by SW/Designee to ensure code status is accurate and matches all locations weekly X 4 weeks then monthly X 3 months with results reviewed by QAA Committee.	

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F 578	Continued From page 16 During an interview on 8/22/23, at 11:21 a.m., registered nurse (RN)-C indicated the facility had a clip board in the nurses' station which listed all of the facility's residents' code status and that code status could also be found in the resident's hard chart. On 8/22/23 at 11:23 a.m., review of the facility Order Listing Report, dated 8/22/23, included all resident's names and code status. The form was on a clip board hanging on the wall, above the desk in the nurse's station. The form identified R25's Advance Directive: DNR. During an interview on 8/22/23 at 12:19 p.m., RN-A stated her usual practice to identify a residents' code status was to first look on the facility clip board hanging in the nursing office. RN-A indicated the advance directives were also kept in the resident paper charts, and orders. RN-A confirmed on the clip board in the nurses' office R25's code status was DNR. RN-A stated R25's paper chart indicated Code Status Consent Form, dated 2/15/23, directed Full Code status. Further, R25's EMR identified code status of DNR. RN-A stated they had R25's care conference that morning where R25's code status was reviewed with R25 and stated he wanted to be DNR. RN-A indicated R25's Code Status Consent Form needed to be updated in hard chart. The facility policy titled Advance Directives revised 12/2016, identified the plan of care for each resident would be consistent with his or her documented treatment preferences and/or advance directive. The policy further identified changes or revocations of a directive must be	F 578		

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F 578	Continued From page 17 submitted in writing to the Administrator. The Administrator may require new document if changes were extensive. The Care Plan Team would be informed of such changes and/or revocations so that appropriate changes could be made in the resident assessment (MDS) and care plan. The policy lacked guidance on the facility forms used and the multiple places resident code status may be identified.	F 578		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		9/26/23

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F 636	Continued From page 18 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete a comprehensive assessment for 1 of 1 resident (R29) who was reviewed for positioning (assistive devices).	F 636	F636: Comprehensive assessment completed to determine need for percussion vest and TSLO for R 29. Plan of care updated for R 29 to include assistive devices. All residents reviewed to ensure appropriate assistive devices	

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F 636	Continued From page 19 Finding include: R29's significant change Minimum Data Set (MDS) dated 5/16/23, indicated moderately impaired cognition and required extensive assistance to complete all activities of daily living (ADL's). Diagnoses included scoliosis (sideways curvature of the spine), spondylosis (condition in which there is abnormal wear on the cartilage and bones of the neck), spinal stenosis (happens when the space inside the backbone is too small), and spastic quadriplegic cerebral palsy (usually cannot walk, and are more likely to have multiple associated conditions, like speech difficulties or seizures and functional limitation bilaterally in both upper and lower extremities. R29's care plan dated 4/17/23, indicated Cerebral Palsy and at risk for declines in medical conditions and ADL's. The care plan directed staff to assist in maintaining good body alignment to prevent contractures. Record review lacked evidence of an order, assessment and care planning for percussion vest treatment, (completed nightly). Further, the record lacked evidence for the TSLO (thoraco-lumbo-sacral orthosis, which is a brace that provides support from mid to the lower portion of the spine) brace worn during the day. During observation on 8/21/23 at 1:13 p.m., R29 had a hard vest present around chest and trunk. It appeared difficult for R29 to move. During interview on 8/22/23 at 3:35 p.m., licensed practical nurse (LPN)-B stated R29 wore the hard vest all day long. It was removed at night but had a vest percussion treatment every evening.	F 636	are in place and plan of care is updated. Policies and Procedures reviewed without changes. Audits to be completed by DON/Designee for all resident□s with assistive devices/positioning devices weekly X 4 weeks then monthly X 3 months with results reviewed by QAA Committee.	

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F 636	Continued From page 20 During interview on 8/22/23 at 2:39 p.m., nursing assistant (NA)-B stated R29 has a hard brace put on in the morning and then taken off at night. NA-B indicated that the aides applied the vest and the nurse took it off. NA-B stated R29 has a percussion vest used around 7 p.m., that the nurses applied. During interview on 8/23/23 at 3:21 p.m., assistant director of nursing (ADON) stated R29 wore a TSLO brace during the day and confirmed there was currently no order, assessment, or care planning in the medical record. ADON stated it should be on the treatment administration record (TAR). ADON also confirmed there was no current order, assessment or care planning for the nightly percussion vest treatment and it should also be on the TAR. ADON stated staff should not perform any treatment without a doctor's order. The facility Assistive Devices and Equipment policy dated 7/17, identified the facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documents in the resident's plan of care.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		9/26/23

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F 656	Continued From page 21 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 656	Continued From page 22 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement a comprehensive care plan for 1 of 1 resident's (R192) reviewed for accidents. Findings Include: Significant change Minimum Data Set (MDS) dated 1/21/23, identified R192 was cognitively intact and was able to clearly communicate needs and wishes. Further, R192 required extensive assistance of two or more persons for her activities of daily living (ADL's) including bed mobility, transfer, and toileting. R192's care plan revised on 12/27/22, identified self-care deficit requiring assistance with ADL's, and non-weight bearing to left lower extremity, The care plan indicated R192 required two persons assistance for toileting, transfers, bathing, and showering. The Nursing Home Incident Report (NHIR) read as follows: "the care plan was being followed correctly at the time of the incident/event." However, the NHIR also read "C.N.A took resident to her room after supper. They were doing her normal routine of getting ready for bed brushed teeth and wiped face, put on nightgown then rolled resident into restroom toilet. When done using toilet, C.N.A got her up with resident holding handrail to wipe her behind. At that moment, resident started to slip and fall onto the floor." Indicating only one staff member was assisting with transfer from the toilet.	F 656	F656: R192 has discharged from the facility. All residents reviewed to insure comprehensive care plans are implemented. Policies and Procedures reviewed without changes. Audits to be completed by DON/Designee to ensure all residents have comprehensive care plans implemented weekly X 4 then monthly X 3 and results reviewed by QAA Committee.	

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F 656	Continued From page 23 During interview on 8/23/23 at 5:53 p.m., RN-B stated they were not able to find any changes had been made in R192's plan of care since 12/27/22. She stated the resident was care planned to be an assist of two when toileting and was an assist of one for dressing and grooming only. Based on the facility investigation one nursing assistant (NA) was assisting the resident at the time of the accident. RN-B stated the care plan was not followed, there was no major injury, and the NHIR was incorrect.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		9/26/23

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F 657	Continued From page 24 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure quarterly care conferences were conducted for 1 of 1 resident (R8) reviewed for care planning. Findings include: R8's quarterly Minimum Data Set (MDS) dated 6/9/23, indicated R8 was admitted on 12/15/22, and had no cognitive deficits. Progress notes indicated R8's last care conference was on 3/21/23. During an interview on 8/21/23 at 2:11 p.m., R8 stated she had not met with anyone regarding her care plan for a long time but thought she should be due for one. R8 stated she had asked about it but a care conference has never been scheduled. During an interview on 8/23/23 at 2:49 p.m., social service designee (SS)-A indicated she was responsible for facilitating care conferences. SS-A stated care conferences are done with every quarterly assessment or with a significant change. Care conferences were done quarterly at the minimum. SS-A confirmed R8's last care conference was on 3/21/23. SS-A stated care conferences were important so that everyone was aware of any changes with the resident or concerns the resident and/or representative may have. During an interview on 8/23/23 at 3:51 p.m., the	F 657	F657: Quarterly care conference conducted for R8. All residents reviewed to ensure quarterly care conferences are current or scheduled. Policies and Procedures reviewed without changes. Audits to be completed by DON/Designee to ensure quarterly care conferences were conducted weekly X 4 then monthly X 3 and results reviewed by QAA Committee.	

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F 657	Continued From page 25 assistant director of nursing (ADON) stated care conferences were scheduled by social worker designee and were completed at least quarterly. ADON stated care conferences were important to occur on a regular basis to keep everyone on the same page and to address any changes in the resident or any concern they may have. No facility policy on care planning was provided.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and provide proper wheelchair positioning for 1 of 1 resident (R12) reviewed for positioning needs. Findings include: R12's quarterly Minimum Data Set (MDS) dated 6/1/23, identified R12 had intact cognition and diagnoses which included: morbid obesity, spinal stenosis (lumbar region), and osteoarthritis. R12 required extensive assistance with mobility that included positioning, transfers and utilized a wheelchair for mobility.	F 684	F684: R12 reviewed by therapy department to ensure wheelchair positioning is appropriate. All residents reviewed to ensure appropriate positioning devices are in place through the use of our quarterly screens. Policies and Procedures reviewed without changes. Audits to be completed by DON/Designee for all resident□s with assistive devices/positioning devices to ensure they are appropriate and have appropriate care plans weekly X 4 weeks then monthly X 3 months with results reviewed by QAA Committee.	9/26/23

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F 684	Continued From page 26 Care plan dated 4/17/23, indicated R12 had a self-care deficit as evidence by requiring assistance with activities of daily living (ADLs), impaired balance during transitions requiring assistance and/or walking, incontinence. R12 is an extensive assistance of two staff with mechanical lift for transfers. Progress notes indicated R12 was seen by occupational therapy (OT) from 5/16/23 to 6/13/23. OT Progress note dated 5/24/23, indicated nursing reported that R12 slides down in the wheelchair. R12 sitting in aligned position for upper body with lower extremities not in an aligned position. Seat cushion is too narrow for the wheelchair. Certified occupational therapy assistant (COTA) asked for a wheelchair cushion to be ordered. COTA sent a message to the DME for wheelchair consult to see when assessment could be scheduled. COTA educated R12 on plan for consult with DME. OT Progress note dated 6/3/23, indicated R12 was educated on possibly looking into whether his insurance provider will authorize a custom wheelchair related to medical necessity and recommend a consult with durable medical equipment (DME) provider to be set up as indicated During observation on 8/21/23 at 12:10 p.m., R12's wheelchair had a pillow across the raised foot pedals that was secured on with a transfer belt wrapped around foot pedals/pillow. During observation on 8/22/23 at 8:20 a.m., R12 was sitting up in wheelchair in the dining room. R12 had legs elevated on a pillow that were across raised foot pedals. R12's legs were bent at the knees. At 9:26 a.m., R12 was done with breakfast and was gradually sliding down in	F 684		

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F 684	Continued From page 27 wheelchair. R12 was yelling at staff that he was going to be on the floor in a minute. Staff radioed for assistance and escorted R12 to room to reposition. As R12 was leaving dining room, R12 had slid down in wheelchair with his head/neck resting on the top of the back of wheelchair. During observation on 8/23/23, at 8:41 a.m., R12 was sitting up in wheelchair in the dining room. R12's legs were elevated on a pillow that was across raised foot pedals. R12's was sliding down in wheelchair, had his feet extended past the end of the foot pedals and his shoulders at the top of the back of the wheelchair. During interview on 8/22/23, at 10:32 a.m., R12 stated he only liked to get up in his wheelchair for meals as the wheelchair was uncomfortable and hurt his coccyx. R12 stated he slid down due to trying to get more comfortable and was not able to boost himself back up. During interview on 8/23/23 at 2:39 p.m., nursing assistant (NA)-B stated R12 does not like getting up in his wheelchair because of pain on his coccyx. NA-B indicated staff get R12 up last, so he doesn't have to sit so long and that R12 slid down in his wheelchair "all the time" due to being uncomfortable. During interview on 8/23/23 at 3:21 p.m., assistant director of nursing (ADON) confirmed she was aware R12 slid down in the wheelchair. ADON stated R12 was not up in wheelchair much and staff waited to get R12 up from bed until the last minute. ADON stated when a resident had difficulty with wheelchair positioning, the provider was notified of what was being observed and would try to get an order for occupational therapy	F 684		

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F 684	Continued From page 28 (OT) to evaluate and treat. ADON stated when positioning continued to be a problem after OT evaluation, the provider was notified again to see if an orde, for a specialized wheelchair could be obtained with a reason why it would be medically necessary to get a wheelchair ttha was fitted properly for resident. ADON confirmed no follow-up had been done on R12's wheelchair positioning after OT evaluation and stated it had slipped through the cracks. The facility Assistive Devices and Equipment policy dated 7/17, identified the facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents. 5.The following factors will be addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment. a. Appropriateness for resident condition - the resident will be assessed for lower extremity strength, range of motion, balance and cognitive abilities when determining the safest use of devices and equipment. b. Personal fit - the equipment or device will be used only according to its intended purpose and will be measured to fit the resident's size and weight.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and	F 685		9/26/23

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F 685	Continued From page 29 §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide follow up audiology services for 1 of 1 resident (R29) reviewed. Findings include: Significant change minimum data set (MDS) dated 5/16/23, identified R29 had moderate cognitive impairment and diagnoses included sensorineural hearing loss, bilateral and dysphonia. MDS further identified R29 required assistance/supervision from staff for all activities of daily living (ADL's) and had hearing aids. Resident record indicated R29's last audiology appointment was on 8/11/22. Audiologist directed to follow up as needed for hearing aid checks. Care Conference summary dated 4/10/23, indicated R29 had stated he would like to figure something out to see if hearing aids would stay in his ears. Care plan dated 4/17/19, indicated staff to encourage R29 to wear hearing aids in both ears, assist with application and removal as needed; Staff to monitor/document/report as necessary any changes in ability to communicate, contributing factors for communication, and potential for improvement/decline; and refer to	F 685	F685: Audiology appointment scheduled for R29. All residents reviewed to ensure they are satisfied with hearing devices/hearing devices are in place as directed or audiology appointments scheduled. Policies and Procedures reviewed without changes. Audit to be completed by DON/Designee to ensure residents are satisfied with their hearing devices weekly X 4 weeks then monthly X 3 months with results reviewed at QAA meetings..	

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F 685	Continued From page 30 audiology as indicated. During observation and interview on 8/21/23 at 12:15 p.m., R29 stated he was very hard of hearing and wished he could hear better. R29 did not have any hearing aids in. During observation on 8/22/23 at 8:23 a.m., R29 was seated in the dining room and did not have hearing aids in either ear. During interview on 8/22/23, at 3:35 p.m., licensed practical nurse (LPN)-B stated R29 was very hard of hearing. He had hearing aids that he used to wear but they kept falling out. During interview on 8/23/23 at 2:39 p.m., nursing assistant (NA)-B stated R29 had hearing aids, but received a new pair awhile back and now R29 didn't like wearing them anymore as they don't fight right. During interview on 8/23/23 at 3:21 p.m., assistant director of nursing (ADON) stated R29 had a newer enhancing device he liked better than the hearing aids but didn't use them on a daily basis. ADON stated she was not sure why there was no follow up on R29's complaints of hearing aids not fitting right. A hearing and vision policy was requested but not provided.	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		9/26/23

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F 688	Continued From page 31 range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure ordered hand brace was applied consistently to maintain range of motion for 1 of 1 resident (R23) reviewed for position and mobility. Findings include: R23's quarterly Minimum Data Set (MDS) dated 6/20/23, identified R23 had intracranial injury with loss of consciousness status and quadriplegia. Care plan dated 4/17/23, indicated R23 had a self-care deficit requiring assistance with activities of daily living (ADLs). Staff to assist with right hand brace, on in AM and off at HS (hour of sleep). Inspect skin and report any hot spots or impairment to charge nurse. Rolled washcloth into hand at HS (hour of sleep). During observation on 8/21/23 at 12:22 p.m., R23's right hand was contracted with fingernails	F 688	F688: R23 orders obtained to ensure R hand is protected from skin breakdown and OT orders obtained for assessment of necessity of hand brace and maintenance of hand ROM. All residents reviewed to ensure proper assistive devices are in place to maintain appropriate ROM through the use of our quarterly screening process. Policies and Procedures reviewed without changes. Audits to be conducted by DON/Designee devices in place to prevent decrease in ROM weekly X 4 weeks then monthly X 3 months with results reviewed by QAA Committee.	

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F 688	Continued From page 32 digging into palm of right hand. R23 had a rolled washcloth in place between his thumb and first finger. During observation on 8/22/23 at 8:16 a.m., R23 had a rolled washcloth, in right hand, between fingers and palm. During observation on 8/22/23 at 4:31 p.m., R23 continued to have a rolled washcloth, in right hand, between fingers and palm. During interview on 8/22/23 at 4:45 p.m., licensed practical nurse (LPN)-B stated staff apply a rolled washcloth in R23's right hand due to contractures. LPN-B stated R23 had a hand brace that he used during the day but has not been using it due to it not fitting correctly. During interview on 8/23/23 at 2:30 p.m.., nursing assistant (NA)-B stated staff apply a rolled washcloth in R23's right hand. NA-B stated R23 did have a brace but that it had not been seen in a long time. During interview on 8/23/23 at 3:21 p.m., assistant director of nursing (ADON) stated staff were aware of what devices a resident needed from the treatment orders and the care plan. ADON stated R23 had a brace for his right hand, but the Velcro was worn out. ADON stated she was not aware of why a new brace had not been obtained for R23. ADON indicated when a device was not available, the doctor should was notified the resident was not using the device and an order should be obtained for it to be discontinued until device was available for resident to use. ADON confirmed an order remained in R23's record for hand brace and that hand brace was	F 688		

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F 688	Continued From page 33 not being used due to it not being available. ADON stated the hand brace was important to help with contractures, pain, and skin breakdown. The facility Resident Mobility and Range of Motion policy dated 7/17, indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM and residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 693		9/26/23

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F 693	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an enteral (feeding) tube was consistently check for placement prior to the administration of medications and enteral nutrition for 1 of 1 resident (R23) whose medication administration and enteral nutrition was offered through a stomach tube. Findings include: R23's quarterly Minimum Data Set (MDS) dated 6/20/23, identified R23 had intracranial injury with loss of consciousness status following decline in status as evidenced by need for tube feeding to meet nutritional needs. R23's current orders dated 4/29/23, identified a G-tube (gastrostomy tube) (a type of tube going straight into the stomach) and received medications and enteral nutrition given directly into stomach. During observation and interview on 8/22/23 at 4:31 p.m., licensed practical nurse (LPN)-B performed medication administration and tube feeding in R23's room following medication review, gathering a new syringe, and a beaker of water. LPN-B raised the head of the bed, donned clean gloves, used stethoscope to listen to bowel sounds to check for placement. LPN-B did not check the placement of the tube using air or water flush prior to 60 mL flush of water. LPN-B continued to administer crushed medication through G-tube. LPN-B stated she checked tube placement by listening to bowel sounds to ensure proper placement.	F 693	F693 G and J tube placement verified for R23. No other residents residing in facility have a G or a J tube. Staff educated on importance of checking for tube feeding placement prior to administration of nutrition and medications. Also reviewed policy and procedure for tube feedings. Policies and Procedures reviewed without changes. Audits to be completed by DON/Designee for all resident□s with tube feedings daily X 1 week, then weekly X 4 weeks, then monthly X 3 months with results reviewed at QAA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 08/23/2023

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F 693	Continued From page 35 During interview on 8/23/23 at 3:31 p.m., assistant director of nursing (ADON) stated checking tube placement was done by flushing g-tube with water while listening with stethoscope over site to hear the water flow. ADON stated it was important to check for placement to ensure the water flushes, medications and feedings are going to the proper location for absorption and nutrition. ADON stated listening to bowel sounds without flushing was not the appropriate way to listen for tube placement. During interview on 8/23/23 at 4:16 p.m., director of nursing (DON) said her expectations of skilled nursing staff administering medication and tube feeding through a G-tube was to check for tube placement prior to every administration. The DON stated, "I would put a little air in tube and listen for it with a stethoscope on the other end." DON stated it was not appropriate to listen to bowel sounds to check for tube placement. DON stated it was important to make sure that the medications and feedings are going in the right location. The facility Enteral Tube Feeding via Continuous Pump policy dated 11/2018, identified purpose, preparation, general guidelines, equipment and supplies, steps in the procedure, initiate feeding, documentation, and reporting. Under steps in the procedure on step 8, the policy identified verify placement of tube.	F 693		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		9/25/23

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F 880	Continued From page 36 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 37 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement appropriate infection prevention and control practices regarding disinfection of mechanical lifts for 6 of 6 residents (Rooms 104, 103, 106, 102, 105, and 117) who utilized a multi-person use lift. Room 104's quarterly Minimum Data Set (MDS) dated 6/20/2023, identified extensive assist of two with transfers. Room 103's quarterly MDS dated 6/20/2023, identified extensive assist of two with transfers.	F 880	F880: Audits to ensure lifts are cleaned before and after use. Reviewing infection control policy and procedure and education on importance of breaking the chain of infection. Audits to be completed by DON/Designee on all staff daily X 1 week, then weekly X 4 weeks, then monthly X 3 months and reviewed at QAA meeting.	

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F 880	Continued From page 38 Room 106's significant change MDS dated 6/20/2023, identified extensive assist of two with transfers. Room 102's significant change MDS dated 5/22/2023, identified extensive assist of one with transfers. Room 105's quarterly MDS dated 6/1/2023, identified extensive assist of two with transfers. Room 117's significant change MDS dated 6/21/2023, identified extensive assist of two with transfers. During observation on 8/21/23 at 1:01 p.m., there were no disinfectant wipes located on any of three mechanical lifts located in the Pine hallway. At 1:17 p.m. staff brought mechanical Hoyer lift into room 104 and when completed returned lift to hallway without disinfecting lift. At 1:22 p.m. staff took mechanical lift in room 103 and when completed returned lift to hallway without disinfecting lift. At 1:30 p.m., staff brought EZ stand mechanical lift into room 106 and when completed returned lift to hallway without disinfecting lift. At 1:39 p.m., staff brought EZ stand mechanical lift into room 102 and when completed returned lift to hallway without disinfecting lift. At 1:48 p.m., staff brought mechanical Hoyer lift into room 105 and when completed returned lift to hallway without disinfecting lift. At 2:08 p.m. staff brought mechanical Hoyer lift into room 117 and when completed returned lift to hallway without disinfecting lift. During interview on 8/23/23 at 2:39 p.m., nursing assistant (NA)-B stated disinfection of the	F 880		

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F 880	Continued From page 39 mechanical lifts should be done between residents. NA-B stated there were usually purple-top wipes on each lift and confirmed that all lifts were missing disinfecting wipes. During interview on 8/23/23 at 3:04 p.m., assistant director of nursing (ADON) stated the process and expectation was to disinfect the mechanical lifts between each resident use. Staff were to use the purple top Sani-wipes, that should be present on each lift, to disinfect lift. ADON stated the disinfection of the lifts was important to prevent the spread of infection. During interview on 8/23/23 at 4:16 p.m., director of nursing (DON) stated mechanical lift should have a container of purple top Sani-wipes. All lifts were to be disinfected between each use. DON stated disinfection of the lifts was important to prevent the spread of infection. The Cleaning and Disinfection of Resident-Care Items and Equipment policy dated 10/18, indicated that durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: State Nursing Home Licensing Orders
Event ID: 2J7811

Dear Administrator:

The above facility was surveyed on August 21, 2023 through August 23, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 08/23/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/21/23 through 8/23/23 a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey and NO licensing orders were issued MN94886/H53604631C MN88127/H53604635C MN86353/H53604636C MN87886/H53604637C MN87909/H53604638C The following complaints were reviewed with licensing order cited: MN90935/H53604634C Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to	2 540		9/25/23

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2 540	Continued From page 3 Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete a comprehensive assessment for 1 of 1 resident (R29) who was reviewed for positioning (assistive devices). Finding include: R29's significant change Minimum Data Set (MDS) dated 5/16/23, indicated moderately impaired cognition and required extensive assistance to complete all activities of daily living	2 540	Corrected	

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2 540	Continued From page 4 (ADL's). Diagnoses included scoliosis (sideways curvature of the spine), spondylosis (condition in which there is abnormal wear on the cartilage and bones of the neck), spinal stenosis (happens when the space inside the backbone is too small), and spastic quadriplegic cerebral palsy (usually cannot walk, and are more likely to have multiple associated conditions, like speech difficulties or seizures and functional limitation bilaterally in both upper and lower extremities. R29's care plan dated 4/17/23, indicated Cerebral Palsy and at risk for declines in medical conditions and ADL's. The care plan directed staff to assist in maintaining good body alignment to prevent contractures. Record review lacked evidence of an order, assessment and care planning for percussion vest treatment, (completed nightly). Further, the record lacked evidence for the TSLO (thoraco-lumbo-sacral orthosis, which is a brace that provides support from mid to the lower portion of the spine) brace worn during the day. During observation on 8/21/23 at 1:13 p.m., R29 had a hard vest present around chest and trunk. It appeared difficult for R29 to move. During interview on 8/22/23 at 3:35 p.m., licensed practical nurse (LPN)-B stated R29 wore the hard vest all day long. It was removed at night but had a vest percussion treatment every evening. During interview on 8/22/23 at 2:39 p.m., nursing assistant (NA)-B stated R29 has a hard brace put on in the morning and then taken off at night. NA-B indicated that the aides applied the vest and the nurse took it off. NA-B stated R29 has a percussion vest used around 7 p.m., that the	2 540		

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2 540	Continued From page 5 nurses applied. During interview on 8/23/23 at 3:21 p.m., assistant director of nursing (ADON) stated R29 wore a TSLO brace during the day and confirmed there was currently no order, assessment, or care planning in the medical record. ADON stated it should be on the treatment administration record (TAR). ADON also confirmed there was no current order, assessment or care planning for the nightly percussion vest treatment and it should also be on the TAR. ADON stated staff should not perform any treatment without a doctor's order. The facility Assistive Devices and Equipment policy dated 7/17, identified the facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documents in the resident's plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to comprehensive assessments and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		9/25/23

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement a comprehensive care plan for 1 of 1 resident's (R192) reviewed for accidents. Findings Include: Significant change Minimum Data Set (MDS) dated 1/21/23, identified R192 was cognitively intact and was able to clearly communicate needs and wishes. Further, R192 required extensive assistance of two or more persons for her activities of daily living (ADL's) including bed mobility, transfer, and toileting. R192's care plan revised on 12/27/22, identified self-care deficit requiring assistance with ADL's, and non-weight bearing to left lower extremity, The care plan indicated R192 required two persons assistance for toileting, transfers, bathing, and showering. The Nursing Home Incident Report (NHIR) read as follows: "the care plan was being followed correctly at the time of the incident/event." However, the NHIR also read "C.N.A took resident to her room after supper. They were doing her normal routine of getting ready for bed brushed teeth and wiped face, put on nightgown then rolled resident into restroom toilet. When done using toilet, C.N.A got her up with resident holding handrail to wipe her behind. At that moment, resident started to slip and fall onto the floor." Indicating only one staff member was assisting with transfer from the toilet.	2 565	Corrected	

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	00314	A. BUILDING: _____ B. WING _____	C 08/23/2023

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2 565	Continued From page 7 During interview on 8/23/23 at 5:53 p.m., RN-B stated they were not able to find any changes had been made in R192's plan of care since 12/27/22. She stated the resident was care planned to be an assist of two when toileting and was an assist of one for dressing and grooming only. Based on the facility investigation one nursing assistant (NA) was assisting the resident at the time of the accident. RN-B stated the care plan was not followed, there was no major injury, and the NHIR was incorrect. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if	2 620		9/25/23

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2 620	Continued From page 8 any; l. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the resident's medical record to ensure resident's wishes would be implemented correctly in an emergency for 1 of 14 residents (R25) reviewed for advanced directives. Findings Include: R25's quarterly Minimum Data Set (MDS) dated 5/10/23, identified moderate cognitive impairment and diagnoses which included: type 2 diabetes mellitus, essential hypertension, Parkinson's disease, and stage 4 chronic kidney disease. R25's MDS further identified R25 required extensive assistance from staff for all activities of daily living (ADL's). R25's care plan revised 8/9/23, identified R25's	2 620	Corrected	

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2 620	Continued From page 9 advance directives were DNR (do not resuscitate). R25's electronic medical record (EMR) identified the following: -R25's Order Summary Report identified Advance Directive: DNR -R25's dashboard Profile (viewed on computer screen) identified Advance Directive: DNR. R25's paper chart identified the following: -R25's Provider Orders for Life-Sustaining Treatment (POLST) Form signed 2/15/23, identified FULL CODE - Resident and/or legal representative DOES want resident to be resuscitated. This resident is considered a "FULL CODE" status. During an interview on 8/22/23, at 10:45 a.m., R25's daughter stated R25 has answered his code status wishes in different ways in the past year. R25's daughter stated that she knows what it says on paper but that R25 will answer if differently when asked. During an interview on 8/22/23, at 11:21 a.m., registered nurse (RN)-C indicated the facility had a clip board in the nurses' station which listed all of the facility's residents' code status and that code status could also be found in the resident's hard chart. On 8/22/23 at 11:23 a.m., review of the facility Order Listing Report, dated 8/22/23, included all resident's names and code status. The form was on a clip board hanging on the wall, above the desk in the nurse's station. The form identified R25's Advance Directive: DNR. During an interview on 8/22/23 at 12:19 p.m.,	2 620		

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2 620	Continued From page 10 RN-A stated her usual practice to identify a residents' code status was to first look on the facility clip board hanging in the nursing office. RN-A indicated the advance directives were also kept in the resident paper charts, and orders. RN-A confirmed on the clip board in the nurses' office R25's code status was DNR. RN-A stated R25's paper chart indicated Code Status Consent Form, dated 2/15/23, directed Full Code status. Further, R25's EMR identified code status of DNR. RN-A stated they had R25's care conference that morning where R25's code status was reviewed with R25 and stated he wanted to be DNR. RN-A indicated R25's Code Status Consent Form needed to be updated in hard chart. The facility policy titled Advance Directives revised 12/2016, identified the plan of care for each resident would be consistent with his or her documented treatment preferences and/or advance directive. The policy further identified changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new document if changes were extensive. The Care Plan Team would be informed of such changes and/or revocations so that appropriate changes could be made in the resident assessment (MDS) and care plan. The policy lacked guidance on the facility forms used and the multiple places resident code status may be identified. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for implementing advanced directives. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing	2 620		

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2 620	Continued From page 11 compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 620		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an enteral (feeding) tube was consistently check for placement prior to the administration of medications and enteral nutrition for 1 of 1 resident (R23) whose medication administration and enteral nutrition was offered through a stomach tube. Findings include: R23's quarterly Minimum Data Set (MDS) dated	2 930	Corrected	9/25/23

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2 930	Continued From page 12 6/20/23, identified R23 had intracranial injury with loss of consciousness status following decline in status as evidenced by need for tube feeding to meet nutritional needs. R23's current orders dated 4/29/23, identified a G-tube (gastrostomy tube) (a type of tube going straight into the stomach) and received medications and enteral nutrition given directly into stomach. During observation and interview on 8/22/23 at 4:31 p.m., licensed practical nurse (LPN)-B performed medication administration and tube feeding in R23's room following medication review, gathering a new syringe, and a beaker of water. LPN-B raised the head of the bed, donned clean gloves, used stethoscope to listen to bowel sounds to check for placement. LPN-B did not check the placement of the tube using air or water flush prior to 60 mL flush of water. LPN-B continued to administer crushed medication through G-tube. LPN-B stated she checked tube placement by listening to bowel sounds to ensure proper placement. During interview on 8/23/23 at 3:31 p.m., assistant director of nursing (ADON) stated checking tube placement was done by flushing g-tube with water while listening with stethoscope over site to hear the water flow. ADON stated it was important to check for placement to ensure the water flushes, medications and feedings are going to the proper location for absorption and nutrition. ADON stated listening to bowel sounds without flushing was not the appropriate way to listen for tube placement. During interview on 8/23/23 at 4:16 p.m., director of nursing (DON) said her expectations of skilled	2 930		

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2 930	Continued From page 13 nursing staff administering medication and tube feeding through a G-tube was to check for tube placement prior to every administration. The DON stated, "I would put a little air in tube and listen for it with a stethoscope on the other end." DON stated it was not appropriate to listen to bowel sounds to check for tube placement. DON stated it was important to make sure that the medications and feedings are going in the right location. The facility Enteral Tube Feeding via Continuous Pump policy dated 11/2018, identified purpose, preparation, general guidelines, equipment and supplies, steps in the procedure, initiate feeding, documentation, and reporting. Under steps in the procedure on step 8, the policy identified verify placement of tube. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have the placement of the tube feeding properly checked and medications are administered separately. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of	21565		9/25/23

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21565	Continued From page 14 care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident was comprehensively assessed for self-administration of medications for 3 of 3 residents (R8, R17, and R29), observed for self-administration of medications. Findings include: R8's quarterly MDS dated 6/9/23, identified R8 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's). Review of R8's medication record lacked evidence of R8 being assessed for self-administration of medications. During observation and interview on 8/21/23 at 2:05 p.m., a tube of medicated gel was on the nightstand next to R8's recliner. R8 confirmed she had medicated gel on her nightstand and used it when needed on her shoulders, back and knees. During observation on 8/22/23 at 3:27 p.m., the tube of medicated gel remained on nightstand. R8's electronic health record (EHR) indicated "May NOT self-administer meds". During interview on 8/23/23 at 2:39 p.m., nursing assistant (NA)-B stated she had seen R8 apply the medicated gel to her knees, shoulder blades	21565	Corrected	

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21565	Continued From page 15 and/or lower back. NA-B stated R8 occasionally asked staff to apply it for her, but R8 normally applied it on her own. R17's quarterly MDS dated 8/3/23, indentified cognitively intact and required supervision with walking in corridor, locomotion off unit, eating, personal hygiene, and bathing. During an interview on 8/21/23 at 1:48 p.m., R17 stated concerns about her missing albuterol inhaler. She stated there was a new box on the med cart, but it was empty. R17 had a red inhaler sitting on her side table and stated she only had enough doses for a few more days and needed to talk to LPN-B. On 8/22/23 at 9:51 a.m., R17 was at a table in the dining/common room conversing with another resident. A red inhaler was on the table next to eye glasses and a cellphone. At 10:10 a.m., R17 stood up, put the red inhaler in her front pants pocket and walked away. Interview on 8/22/23 at 10:23 a.m., Licensed Practical Nurse (LPN)-A stated the empty box in the med cart was for the inhaler R17 currently had in her possession. LPN-A stated it looked like another refill had already been ordered from the pharmacy. LPN-A confirmed R17's record lacked evidence of a SAM assessment and order. LPN-A stated the inhaler was one of R17's possessions that helped to keep her calm and she did not use it often. It still had 103 puffs remaining. R29's significant change MDS dated 5/16/23, identified R29 was moderately impaired, and required assistance/supervision with activities of daily living (ADL's).	21565		

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21565	Continued From page 16 Review of R29's medication record lacked evidence of a SAM assessment and order. During observation on 8/21/23 at 1:57 p.m., registered nurse (RN)-C went into R29's room and set up a nebulizer machine and placed a mask on R29's face. The machine was turned on and RN-C left R29's room while the nebulizer was running. During observation on 8/22/23 at 3:14 p.m., R29 was sitting alone in their room. The nebulizer mask was on R29's face and the machine was running. R29 was sleeping, head hanging down making the lower part of the mask not fitted on face allowing solution to go out the bottom. At 3:21 p.m., nursing assistant went into R29's room, shut off nebulizer machine and removed mask. During interview on 8/22/23 at 3:36 p.m., licensed practical nurse (LPN)-B confirmed R8 and R29 did not have a SAM assessment and order. During interview on 8/23/23 at 2:39 p.m., NA-B stated R29 was not able to take nebulizer mask off by himself and the NAs' removed the mask after the treatment was completed. Interview on 8/23/23 at 3:50 p.m., registered nurse (RN)-B stated Self Administration Medication Assessment (SAMA) were completed when a resident requested to self-administer a medication. The results of the assessment were communicated with the care team via fax. They then get a fax back with the providers recommendations and/or order for self-administration. RN-B's expected an assessment would have been completed before the resident was allowed to self-administer the	21565		

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21565	Continued From page 17 medication. RN-B stated she worked in the unit recently, and noticed the resident had her inhaler. R17 stated she was using it herself for a very long time and became upset with RN-B when she needed to observe her use of it and take her oral medications. RN-B stated she should have followed up in this at that time, but she did not. RN-B stated they should also monitor the use of the inhaler to ensure it was used appropriately. During interview on 8/23/23 at 3:21 p.m., assistant director of nursing (ADON) stated in order for a resident to be able to self-administer medications, a self-administration assessment must be completed. Assessments were completed by any nurse. If the resident was determined to be able to self-administer medications, the nurse notified the provider to obtain an order. ADON stated it was important for a resident to be assessed to ensure they received the correct medication and dose. The Self-Administration of Medications policy dated 2016, indicated that the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the residents: a. Ability to read and understand medication labels.	21565		

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21565	Continued From page 18 b. Comprehension of the purpose and proper dosage and administration time for his or her medications. c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. 3. If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. 4. The staff and practitioner will ask residents who are identified as being able to self-administer medications whether they wish to do so. 5. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. 6. For self-administering resident, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken. 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. 9. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party. 13. The staff and practitioner will periodically reevaluate a resident's ability to continue to self-administer medications. SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice staff	21565		

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21565	Continued From page 19 regarding the process for determination of resident capability to safely self-administer medications. An audit could be conducted to identify and assess residents who have the capability to participate in self-administration. This could be part of the quality assurance plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of	21825		9/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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21825	Continued From page 20 treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to obtain informed consent including risks and benefits for 4 out of 4 residents (R13, R20, R21, and R37) reviewed for use of psychotropic medications. Findings include: R13's admission Minimum Data Set (MDS) dated 6/26/23, indicated severe cognitive impairment with no evidence of hallucinations and delusions. He has the following: diagnoses of schizophrenia, major depressive disorder, anxiety disorder, and obsessive-compulsive disorder. R13's physician's orders indicated the following psychotropic medication orders: Celexa dated 6/22/23 (an antidepressant), and risperidone dated 6/22/23 (an antipsychotic). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. R20's admission MDS dated 6/15/23, indicated severe cognitive impairment, evidence of hallucinations and delusions and diagnoses of major depressive disorder, dementia without behavioral disturbance and cerebral vascular disease. R20's physician's orders indicated the following	21825	Corrected	

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21825	Continued From page 21 psychotropic medication orders: duloxetine dated 6/15/23, trazodone dated 6/15/23, nortriptyline dated 6/29/23 (all antidepressants), and quetiapine dated 6/15/23 (an antipsychotic). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. R21's quarterly MDS dated 7/10/23, indicated no cognitive impairment, hallucinations or delusions. He does have the following diagnoses: adjustment disorder with depressed mood, mild cognitive impairment of uncertain or unknown etiology, and anxiety disorder. R21's physician's orders indicate the following psychotropic medication orders: buspirone HCL dated 5/25/23 (an anxiolytic) , seroquel dated 5/8/23 (an antipsychotic), and Cymbalta dated 5/8/23 (an antidepressant). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. R37's admission MDS dated 7/21/23, indicated moderately impaired cognition and diagnoses of vascular dementia, cerebral vascular disease, major depressive disorder, and history of traumatic brain injury. R37's physician's orders indicated the following psychotropic medication orders: Sertraline dated 8/20/23 (an antidepressant), and olanzapine dated 8/20/23 (an antipsychotic). However, the record lacked evidence of Informed consents regarding risk versus benefit of these medications. On 8/23/23 at 1:20 p.m., the director of clinical services (DOCS) and licensed practical nurse (LPN-C) confirmed the facility failed to obtain	21825		

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21825	Continued From page 22 informed consents including risk and benefit discussions of all psychotropic medications used by all 4 residents. The facility policy Psychotropic Medications dated 11/28/21, identified "The resident and/or resident representative will be informed prior to the initiation of psychotropic medication." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could review and/or revise current policy and procedure regarding informed consent with education to staff provided on current or revised policy and procedures regarding informed consent. The administrator, director of nurses or designee would initiate a program to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.	21915		9/25/23

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21915	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to establish a family council within the past 12 months. This had the potential to affect 35 residents residing in the facility. When interviewed on 8/23/23, the social service designee (SSD) stated she had not realized attempts to establish a family council was a requirement and that no attempts had been made to establish one in the last 12 months. A faciliy policy regarding family council was requested but not provided. SUGGESTED METHOD OF CORRECTION: The facility's social worker or social service designee could contact resident family members via any method, to invite to participate in a family council meeting. The frequency of the family council meetings could be determined by the family council. Documentation of all meetings and attempts should be maintained. If the first attempt does not yield results, the facility could make another attempt later in the same year. The administrator or designee could monitor the attempts to organize a family council.	21915	Corrected	

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted on 08/23/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Glenoaks Senior Living Campus was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/25/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Glenoaks Senior Living Campus, is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II(000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II(000) construction. In	K 000		

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K 000	Continued From page 2 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II(000) construction. The building is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 52 beds and had a census of 36 at the time of the survey. At the time of this survey, the requirements of 42 CFR, Subpart 483.70(a), are NOT MET.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, 19.2.3.5 and 7.1.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 08/23/2023 at 10:00 AM, it was revealed by	K 211	K211: It is the practice of Glen Oaks Senior Living Community to continually maintain all means of egress free of all obstructions in case of emergency per NFPA 101 standards. CORRECTIVE ACTION:	9/21/23

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K 211	Continued From page 3 observation that there were tables and chairs in the egress corridor in the oak lobby. 2. On 08/23/2023 at 10:45 AM, it was revealed by observation in the egress corridor by laundry approximately 15 boxes that there were being stored. When interviewing the Environmental Services Director it was discovered they have been there for a couple days due to an over order. 3. On 08/23/2023 at 11:30 AM, it was revealed by observation there were wheelchairs and chairs without wheels stored in the Therapy egress corridor. 4. On 08/23/2023 at 10:00 AM, it was revealed by observation an exercise bike (in use at the time of the survey) and weights were in the oak lobby that were being used for therapy. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 211	Glen Oaks identified the four areas that had problens with egress 1. The Oaks lobby area. 2. The hallway near the laundry room 3. The Therapy corridor 4. The exercise bike in the Oak lobby. The Maintenance staff has removed furniture from the Oak Lobby, removed all boxes from the hall near the laundry, removed all wheelchairs and sofa chairs from the therapy hall, and relocated the exercise bike to the Therapy Gym. MEASURES TO PREVENT REOCCURRANCE: Then Maintenance Director will place signs in the Laundry and Therapy hallways to read, "Keep Halls Clear of any Storage." The Maintenance Director will conduct walk-through Audits daily for 7 days, then once a week for 3 weeks, then once a month for 3 months, to ensure continued compliance. The Maintenance Director is responsible for compliance and communicating results of the audits to the QAPI Committee. Administrator will also provide oversight on monitoring hallways to be free of stored objects. The QAPI Committee will utilize the data to guide further compliance monitoring and training. ACTUAL/PROPOSED DATE OF REMEMDY: The facility alleges that it will be in substantial compliance and complete all corrective items by September 21, 2023.	

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 between 10:00am and 1:00pm, it was revealed by a review of available documentation the facility failed to provide	K 353	K353 Sprinkler system - Maintenance and testing CFR(s): NFPA 101 SS=F It is the practice of Glen Oaks Senior Living to maintain testing and maintenance records of the automatic sprinkler and standpipe systems in accordance with NFPA 25. Based on observation, the facility failed to test and maintain records of the quarterly sprinkler system test. CORRECTIVE ACTION	9/21/23

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K 353	Continued From page 5 documentation for quarterly sprinkler inspections for the 2nd and 3rd quarter of 2023 and the 4th quarter of 2022. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 353	The Maintenance Director has been educated on the on the requirements to conduct 1 test per quarter on the sprinkler system and properly document these tests per NFPA 25 standards. The first sprinkler test was conducted on 9/21/23 and documented on a Sprinkler Test log sheet. MEASURES TO PREVENT REOCCURANCE The Maintenance Director has added the sprinkler test to the fire drill schedule and will utilize the TELS program for email reminders as to when the test is due per quarter. MONITORING/AUDITING The Maintenance Director and Administrator will review compliance weekly for 4 weeks and then monthly thereafter. The maintenance director is responsible for compliance and communicating results to the QAPI Committee. The QAPI Committee will utilize the audit data to guide further compliance monitoring and training. ACTUAL/PROPOSED DATE OF REMEDY The facility alleges that it will be in substantial compliance and complete all corrective action items by September 21, 2023.	
K 511 SS=E	Utilities - Gas and Electric	K 511		9/21/23

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K 511	Continued From page 6 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly secure electrical panel(s) per NFPA 101 (2012 edition), Life Safety Code, section 19.5.1.1, 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.27. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/23/2023 between 10:00 AM to 1:00 PM, it was revealed by observation an electrical panel by therapy and the beauty shop in the resident corridors were found to be unsecured and readily accessible to unqualified individuals. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 511	K511 Utilities □ Gas and Electric. CFR(s): NFPA 101 SS=E It is the practice of Glen Oaks Senior Living to properly secure all electrical panels with locks per NFPA 101 and NFPA 70 standards. Based on observation, the facility failed to lock the 2 electrical panels near the beauty shop and one panel in the therapy hallway. CORRECTIVE ACTIONS The three electrical panels have new hasp and paddle locks installed to allow access to qualified staff only. MEASURES TO PREVENT REOCCURENCE The Maintenance Director will monitor all electrical panels in resident areas on his	

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K 511	Continued From page 7	K 511	daily safety walkthrough of the facility. ACTUAL/PROPOSED DATE OF REMEDY The facility alleges that it will be in substantial compliance and complete all corrective action items by September 21, 2023	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 08/23/2023 at 10:00 AM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 3rd shift	K 712	K712 FIRE DRILLS CFR(S): NFPA 101 SS=F It is the practice of Glen Oaks Senior Living Campus to document the testing and inspection of the fire alarm system and conduct 4 fire drills per year / per shift per NFPA standards. CORRECTIVE ACTION:	9/21/23

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GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE NEW LONDON, MN 56273**

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K 712	Continued From page 8 of the 1st quarter of 2023. 2. On 08/23/2023 at 10:00 AM, it was revealed by a review of available documentation that the facility did not perform a fire drill on the 1st and 2nd shifts of the 4th quarter of 2022. An interview with the Environmental Services Director verified this deficient findings at the time of discovery.	K 712	The Maintenance Director will develop a yearly schedule as directed by Kim Swenson (State Fire Marshal Inspector) to follow, that will lay out the date and time of the monthly fire drills. This schedule is more simplified than the current schedule being used by the Maintenance Director. MEASURES TO PREVENT REOCCURENCE: The Maintenance Director will implement the use of the TELS program and set email reminders for upcoming monthly fire drills. MONITORING/AUDITING: The Maintenance Director and Administrator will review compliance weekly for 3 months, then monthly thereafter. The Maintenance Director is responsible for compliance and communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future monitoring and training. ACTUAL/PROPOSED DATE OF REMEDY: The facility alleges that it will be in substantial compliance and complete all action items by September 21, 2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 918	Continued From page 9 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems,	K 918	K918 ELECTRICAL SYSTEMS ESSENTIAL ELECTRIC SYSTEM CFR(S): NFPA 101 SS=F It is the practice of GlenOaks Senior	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

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GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 918	Continued From page 10 sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/23/2023 at 10:30 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 918	Living Campus to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition) Health Cre facilities Code, section 6.4.4.1.1.4, and NFPA 110(2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. CORRECTIVE ACTION: The Maintenance Director has implemented generator and transfer switches testing, inspection and maintenance in accordance with the required standards and will use the proper weekly and monthly generator forms to document the findings and outcomes. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Interstate Power Systems has been contacted and scheduled for October 4th, 2023 to do the 4 hour load bank test. Scheduled test under load conditions includes a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2023**

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K 918	Continued From page 11	K 918	available. MEASURES TO PREVENT REOCCURENCE: Clipboards have been created with the proper forms and placed in the maintenance office to document the generator testing and inspection per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. The Maintenance Director will utilize the TELS software program to schedule and create reminders of the required testing and inspections. MONITORING/AUDITING: The Maintenance Director and Administrator will review compliance on a weekly basis for 3 months, then monthly thereafter. The Maintenance Director is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future monitoring and training. ACTUAL/PROPOSED DATE OF REMEDY: The facility alleges that it will be in substantial compliance and complete all action items by October 4th, 2023	