Electronically Delivered

November 9, 2023

Licensee
Glenoaks Senior Living Campus
102 Glenoaks Drive
New London, MN 56273

RE: Project Number(s) SL20303015

Dear Licensee:

On November 7, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 24, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

PMB

Electronically Delivered

September 19, 2023

Licensee
Glenoaks Senior Living Campus
102 Glenoaks Drive
New London, MN 56273

RE: Project Number(s) SL20303015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration -$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

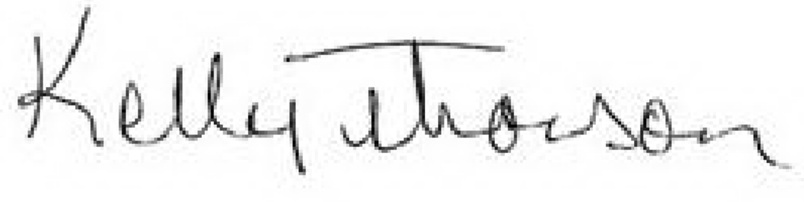
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20303	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	102 GLENOAKS 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) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20303015-0 On August 21, 2023, through August 24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 11 residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on August 22, 2023, issued for SL20303015-0, tag identification 1640. On August 23, 2023, the Immediacy of correction order 1640 was removed, however non-compliance remains at a scope and severity of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairmBased on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 480	Continued From page 2 (21) daysent, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 510	Continued From page 3 unlicensed personnel ((ULP)-E) observed to perform blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 23, 2023, at 11:15 a.m., the surveyor observed ULP-E perform a blood glucose check on R2 in her apartment. ULP-E donned clean gloves, wiped R2's middle finger on her right hand, poked the finger with a lancet, wiped the blood off and placed a sample of the blood on the test strip inserted in the glucometer. ULP-E then handed R2 a tissue to hold on her finger, grabbed the Humalog KwikPen, removed the cap, wiped the top with an alcohol wipe, placed a needle, primed the insulin pen, drew up 10 units, wiped R2's right upper thigh with an alcohol wipe, and administered the insulin. After ULP-E disposed of the needle in the sharps container on the counter, she removed her gloves and washed her hands in the bathroom. On August 23, 2023, at approximately 11:25 a.m., ULP-E stated she had been trained to perform the blood sugar and insulin this way, and had not been trained to perform hand hygiene or removed gloves between the procedures. On August 23, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-A stated she had not heard of	0 510		

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0 510	Continued From page 4 changing gloves and performing hand hygiene between blood sugar testing and insulin administration. The licensee's Blood Sugar Testing - Single Equipment Use policy dated August 1, 2021, noted after the procedure to remove gloves and wash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 5 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 21, 2023, at approximately 10:30 a.m., the surveyor observed the common areas of the facility, and was unable to locate the EPP. At 10:50 a.m., licensed assisted living director (LALD)-B said she had removed the manilla folder with the EPP in April for the annual training and had not put it back in it's place, near the dining room. On August 24, 2023, at 8:50 a.m., the surveyor reviewed the EPP and Appendix Z with LALD-B. At this time, LALD-B stated she had reviewed the missing person policy twice per year, and was not aware of the requirement to be reviewed quarterly.	0 680		

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0 680	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 7 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1) hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and the resident's designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and	01060		

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01060	Continued From page 8 the Office for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R1's diagnoses included stroke, hypertension, and Alzheimer's disease. R1's Progress Notes indicated: - August 2, 2023, R1 was sent to the emergency room after a fall with leg pain. Another note later the same date noted R1 had a hip fracture. - August 7, 2023, R1 was discharged from the hospital and admitted to another hospital for "short rehab stay in a swing bed." - August 14, 2023, R1 readmitted to the facility. On August 24, 2023, at 10:00 a.m., licensed assisted living director (LALD)-B stated some of the information required was discussed with the resident's son on the phone, and she had forms she used to document some information, but no written information was provided to the resident, resident's legal representative or designated representative. The licensee's Emergency Relocation policy dated August 1, 2021, noted in the event of an emergency relocation, the licensee would provide a written notice that include at a minimum the reasons for the relocation, the name and contact information for the location to which the resident had been relocated, the contact information for	01060		

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01060	Continued From page 9 OOLTC, in known and applicable, the approximate date or range of dates the resident was expected to return or a statement the return date was not known, and a statement that, if the facility refused to provide housing or services after a relocation, the resident had a right to appeal including the contact information for the agency to which the resident may submit an appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted	01290		

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01290	Continued From page 10 living license for one of three employees (unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on June 9, 2023, to provide direct care services to the facility's residents. On August 22, 2023, from 7:36 a.m. to 7:50 a.m., the surveyor observed ULP-C administer medications to residents. ULP-C's employee record contained a Background Study Clearance dated June 12, 2017, from the attached skilled nursing facility. However, the document was not affiliated with the facility's license. On August 22, 2023, at 9:02 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the licensee's health facility identification (HFID) number was not listed on the clearance letter, and they would have to run this by human resources to look into it. The licensee's Background Studies policy dated August 1, 2021, noted the licensee would conduct a background study on all employees. No further information was provided.	01290		

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	20303	A. BUILDING: _____ B. WING _____	08/24/2023

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01290	Continued From page 11 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of staff performing delegated tasks for two of two employees (unlicensed personnel (ULP)-C, ULP-D).	01440		

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01440	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C began employment on June 9, 2023, to provide direct care services to residents of the assisted living facility. On August 22, 2023, at 7:36 a.m., the surveyor observed ULP-C administer medications to residents in the dining room. ULP-C's employee record lacked documentation of a RN supervising ULP-C performing a delegated task within 30 days of beginning work. ULP-D ULP-D began employment on June 23, 2021, to provide direct care services to residents of the assisted living facility. ULP-D's employee record lacked documentation of a RN supervision ULP-D performing a delegated task within 30 days of beginning work. On August 22, 2023, at 9:17 a.m., clinical nurse supervisor (CNS)-A stated the supervision had not been completed for ULP-C, and stated ULP-D was hired prior to her starting, and added she	01440		

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01440	Continued From page 13 was unable to find documented evidence of it being done for ULP-D. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for the licensee and first performed the delegated tasks for the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,	01470		

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01470	Continued From page 14 including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing	01470		

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01470	Continued From page 15 services for two of three employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C began employment on June 9, 2023, to provide direct care services to residents of the assisted living facility. On August 22, 2023, at 7:36 a.m., the surveyor observed ULP-C administer medications to residents in the dining room. ULP-C's employee record lacked documented evidence of the following: - principles of person-centered planning/service delivery. ULP-D ULP-D began employment on June 23, 2021, to provide direct care services to residents of the assisted living facility. ULP-D's employee record lacked documented evidence of the following: - principles of person-centered planning/service delivery.	01470		

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01470	Continued From page 16 On August 22, 2023, at 9:02 a.m., clinical nurse supervisor (CNS)-A stated person-centered training had not been completed for either staff. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, noted all employees must complete the orientation to assisted living facility requirements before providing services to the residents. It also note the orientation must include principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

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01500	Continued From page 17 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included	01500		

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01500	Continued From page 18 all required topics for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-A CNS-A began employment on February 7, 2022, to provide supervision and direct care services to residents of the assisted living facility. CNS-A's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - principles of person-centered planning/service delivery. ULP-D ULP-D began employment on June 23, 2021, to provide direct care services to residents of the assisted living facility. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - principles of person-centered planning/service delivery.	01500		

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01500	Continued From page 19 On August 22, 2023, at 8:42 a.m., CNS-A stated both employees lack the required annual training listed. The licensee's Annual Required Staff Training policy dated August 1, 2021, noted all staff must receive eight hours of annual training for each month of employment, and the training must include the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01530		

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01530	Continued From page 20 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an assisted living license. CNS-A CNS-A began employment on February 7, 2022, to provide supervision and direct care services to residents of the assisted living facility. CNS-A's employee record contained evidence of five hours of dementia training upon hire through	01530		

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01530	Continued From page 21 May 18, 2023, short of the required eight hours of training within 120 working hours, and the two hours of training for each 12 months of employment. CNS-A reached 120 working hours on March 8, 2022. ULP-C ULP-C began employment on June 9, 2023, to provide direct care services to residents of the assisted living facility. On August 22, 2023, at 7:36 a.m., the surveyor observed ULP-C administer medications to residents in the dining room. ULP-C's employee record contained evidence of one hour dementia training upon hire, short of the required eight hours of training within 160 working hours. ULP-C reached 160 working hours on August 2, 2023. On August 22, 2023, at 9:02 a.m., CNS-A stated she and ULP-C were short of the required eight hours of dementia training, and stated she would have to have the human resources department look into this to get the required training added. The licensee's Dementia Training policy dated August 1, 2021, noted supervisors of direct care staff would complete eight hours of initial training within 120 hours of the employment start date, and direct care employees would complete eight hours of initial training within 160 hours of the employment start date. It also noted all staff would complete two hours additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01530		

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01530	Continued From page 22 (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1,	01650		

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01650	Continued From page 23 R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included stroke, hypertension, and Alzheimer's disease. R1's Service Plan dated August 14, 2023, noted services including assistance with dressing, grooming, toileting, and medication administration. The service plan lacked: - a description of the services to be provided, including compression stockings and incentive spirometer; and - a contingency plan including the identification of and information as to who had authority to sign for the resident in an emergency. R2 R2's diagnoses included type 2 diabetes mellitus, hypertension, and dysphagia (difficulty swallowing). R2's Service Plan dated June 15, 2023, noted services including assistance with dressing, toileting, bathing, and medication administration. The service plan lacked: - a contingency plan including the identification of and information as to who had authority to sign	01650		

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01650	Continued From page 24 for the resident in an emergency. On August 24, 2023, at 8:15 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the plan lacked the required content listed above. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include a description of the services to be provided, and identification and contact information of who the resident had authorized, if any, to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to	01750		

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	20303	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	102 GLENOAKS DRIVE NEW LONDON, MN 56273

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01750	Continued From page 25 delegating the nursing task of medication administration, the unlicensed personnel (ULP) demonstrated competency to a registered nurse (RN) for administering medications for one of one ULP (ULP-C). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate order on August 22, 2023, at 1:45p.m. During the entrance conference on August 21, 2023, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to all of their residents. On August 22, 2023, from 7:36 a.m. to 7:50 a.m., ULP-C was observed to administer medications to residents. On August 22, 2023, at 7:50 a.m., ULP-C stated she was trained by two ULP peers to administer medications, and was not trained by the registered nurse. ULP-C stated she did not have any medication or competency training here in the assisted living facility. On August 22, 2023, at 11:40 a.m., CNS-A stated when a new ULP starts, they are on the floor and observe a peer administering medications. They	01750		

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01750	Continued From page 26 can watch how it is done, talk through it, and ask questions. Then there is a day the new ULP administers medications in the presence of their peer. After this, CNS-A stated she will ask the new ULP questions about medication administration, and if they are able to answer correctly, they pass. CNS-A stated she does spot checks watching the new staff either from afar or next to them, and the training and competency form is signed by the new employee, the peer, and the CNS. ULP-C's employee record contained a Competency Tracking Form dated July 3, 2023, which noted ULP-C was tested on and passed eye drops, subcutaneous injections, nasal spray, and oral medications. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted when the RN delegated tasks, prior to the delegation, they must make certain the ULP was trained in the proper methods to perform the tasks and had demonstrated the ability to competently follow the procedures and perform the tasks. It noted the RN would determine what nursing services may be delegated to properly trained and competency tested ULP. It also noted training and competency evaluations would include administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE IMMEDIACY OF ORDER LIFTED AUGUST 23, 2023 AT 11:15 A.M	01750		

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01760	Continued From page 27	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included type 2 diabetes mellitus, hypertension, and dysphagia (difficulty swallowing).	01760		

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01760	Continued From page 28 R2's Service Plan dated June 15, 2023, noted services including assistance with dressing, toileting, bathing, and medication administration. R2's prescriber orders dated August 10, 2023, included glucose 4 grams, give one table by mouth as needed for hypoglycemia. If resident's blood sugar is below 70 milligram (mg)/deciliter (dL) and resident is alert and able to safely swallow may give one chewable tablet and repeat blood sugar within 15 minutes. On August 23, 2023, at 11:15 a.m., the surveyor observed unlicensed personnel (ULP)-E perform a blood glucose check on R2 in her apartment. ULP-E stated the reading was 69 mg/dL, and she would report this to the nurse per parameters on the order which noted when below 69 mg/dL or above 400 mg/dL the nurse was to be notified. On August 24, 2023, at 8:15 a.m., clinical nurse supervisor (CNS)-A stated the glucose had not been given consistently when the resident's blood glucose was below 70 mg/dL. In addition, CNS-A stated she had not instructed the staff to administer the glucose on August 23, 2023, when a result of 69 mg/dL was reported, and added she was not aware of the order and would have to check with the prescriber to see if they wished this to continue or not. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2023, noted if medication administration was note completed as prescribed, documentation must include the reason why it was not completed and any follow-up procedures provided. No further information was provided.	01760		

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	20303	A. BUILDING: _____ B. WING _____	08/24/2023

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01760	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 21, 2023, at 9:40 a.m., clinical nurse supervisor (CNS)-A said the licensee provided medication management and setup services to all eleven current residents. On August 23, 2023, at 11:35 a.m., the surveyor	01770		

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01770	Continued From page 30 conducted a review of the medication storage with unlicensed personnel (ULP)-E in the medication cart, which contained narcotic medications in a locked compartment. ULP-E stated the nurses did the narcotic setup and the routine medication setup, and she was not sure where this was documented. On August 23, 2023, at 12:35 p.m., clinical nurse supervisor (CNS)-A stated the narcotic medications were documented in a bound notebook. The page marked as 116 for R1 included the date of medication setup, medication name, quantity of dose, and the name of the person completing the medication setup. However, it lacked the times to be administered and the route of administration. On August 24, 2023, at 7:05 a.m., CNS-A stated the medications for all residents are setup by the nurse and documented in the checklist. The checklist contained columns for each resident with the setup and double check for each resident. It also noted week 1 from July 28, 2023, through August 4, 2023, week 2 from August 4, 2023, through August 11, 2023, week 3 from August 11, 2023, through August 18, 2023, and week 4 from August 18, 2023, through August 25, 2023. In each column for the specific week, included the date and initials of the nurse doing the setup and the nurse completing the double check. CNS-A stated they had changed to an electronic medication administration record in February 2023, and were not sure how to document the medication setup electronically, and said the checklist lacked the required content to include the medication name, quantity of dose, times to be administered, and route of administration. CNS-A stated the medication setup for all residents was documented on the	01770		

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01770	Continued From page 31 same form. R1 R1's diagnoses included stroke, hypertension, and Alzheimer's disease. R1's Service Plan dated August 14, 2023, noted services including assistance with dressing, grooming, toileting, and medication administration. R1's prescriber orders dated August 22, 2023, included one blood thinner, two medications to reduce blood pressure, and Tramadol for moderate or severe pain related to fracture of the left femur. R1's record lacked complete documentation by the licensed nurse at the time of medication setup to include the required content. R2 R2's diagnoses included type 2 diabetes mellitus, hypertension, and dysphagia (difficulty swallowing). R2's Service Plan dated June 15, 2023, noted services including assistance with dressing, toileting, bathing, and medication administration. R2's prescriber orders dated August 18, 2023, included two insulin, and one pain reliever. R2's record lacked complete documentation by the licensed nurse at the time of medication setup to include the required content. The licensee's Medication Management - Administration & Setup policy dated August 1, 2021, lacked instructions on the content of the	01770		

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01770	Continued From page 32 documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/21/23*
Time: 10:58:15
Report: 7930231158

Food and Beverage Establishment Inspection Report

Location:
Glenoaks Senior Living Campus
102 Glenoaks Drive
New London, MN56273
Kandiyohi County, 34

Establishment Info:
ID #: 0038683
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203542121
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-201.11

MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

REPLACE THE COUNTERTOP AND CABINETS/DRAWERS IN THE SERVING KITCHEN. BOTH ARE IN DISREPAIR AND NEED TO BE REPLACED.

Comply By: 11/21/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: AMBIENT TEMPERATURE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

Type: Full
Date: *08/21/23*
Time: 10:58:15
Report: 7930231158
Glenoaks Senior Living Campus

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7930231158 of 08/21/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us