



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 29, 2025

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

RE: Project Number(s) SL20303016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

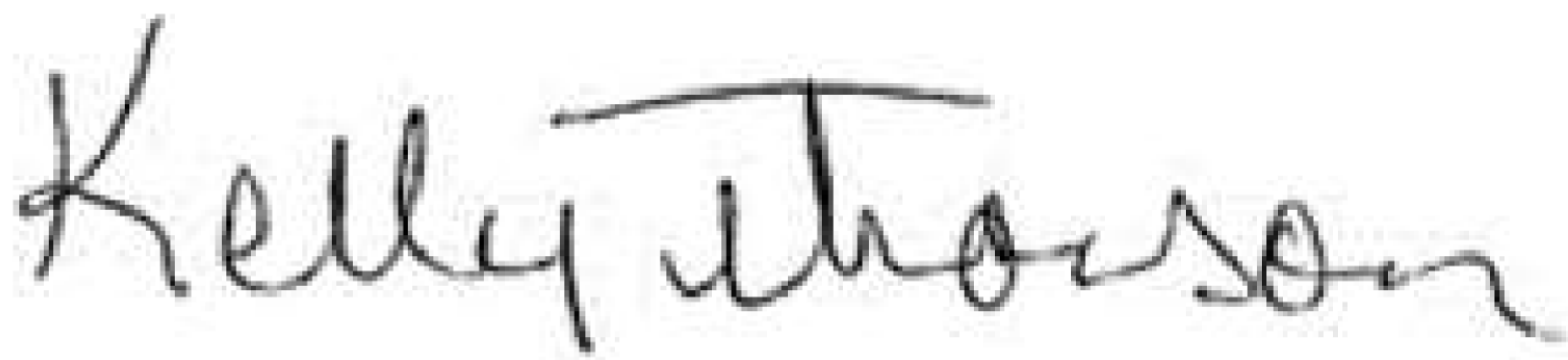
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER GLENOAKS SENIOR LIVING CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 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: SL20303016-0 On September 29, 2025, through October 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were eleven (11) residents all of whom received services under the Assisted Living Facility license.	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 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff,	0 470			

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0 470	Continued From page 2 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 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: The licensee held an assisted living license and was licensed for a capacity of 24 residents, with a current census of 11 residents. During the entrance conference on September 29, 2025, at 9:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had developed the staffing plan. On September 29, 2025, at 12:10 p.m. LALD/CNS -A provided licensee's staffing plan dated April 4, 2025. The licensee's staffing plan lacked evidence a metric was used to determine staffing needs and being reviewed at least twice per year. On October 1, 2025, at 10:25 a.m., LALD/CNS-A stated they were not aware the staffing schedule review was required twice a year and thought it was annually. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3, effective October 2022, the CNS must develop and implement a	0 470			

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0 470	Continued From page 3 written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: (A) each resident's needs, as identified in the resident's service plan and assisted living contract; (B) each resident's acuity level, as determined by the most recent assessment or individualized review; (C) the ability of staff to timely met the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; (D) whether the facility has a secured dementia care unit; and (E) staff experience, training, and competency. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480			

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0 480	Continued From page 4 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480			

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0 480	Continued From page 5 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 29, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued	0 660			

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0 660	Continued From page 6 by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment	0 660			

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0 660	Continued From page 7 dated February 6, 2025, indicated the licensee was a low risk. ULP-B had a hire date of May 5, 2024. ULP-B's record included a TB skin test and symptom screen dated July 21, 2025. The record lacked evidence of TB testing upon hire or within 90 days prior to hire. On October 1, 2025, at 10:26 a.m., licensed assisted living director/clinical nurse supervisor LALD/CNS-A stated they were aware ULP-B's TB test was not performed as required. "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, read "staff whose essential job functions require work within the same air space of residents would be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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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 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 interview and record review, the licensee failed to post an emergency disaster plan prominently and develop a written emergency preparedness plan (EPP) and failed to review the missing person policy quarterly. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a	0 680			

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0 680	Continued From page 9 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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 the residents). The findings include: On September 29, 2025, at 9:35 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A guided surveyor on a facility tour. Upon the tour there was no postage of the licensee's EPP. LALD/CNS-A stated the EPP was stored in LALD/CNS-A locked office and was not aware the EPP was required to be posted in a prominent location. The licensee's April 2025, EPP lacked the required content for the missing resident plan and quarterly review. On October 1, 2025, at 10:26 a.m., LALD/CNS-A stated they were not aware the policy was required to be reviewed quarterly. The licensee's 2.01 Policies and Procedures Overview read "the emergency plan guidelines would be made widely available to all staff and maintained in accordance to states guidelines." The licensee's 2.28 Missing Resident policy dated June 2021, indicated the missing resident procedure will be reviewed at least quarterly. Changes to the plan will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review	0 680			

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0 680	Continued From page 10 missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730			

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0 730	Continued From page 11 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). 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:	0 730			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GLENOKS SENIOR LIVING CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 102 GLENOKS 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
0 730	Continued From page 12 On September 29, 2025, at 12:06 p.m. licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A provided R3's discharge with all required content dated September 29, 2025, upon survey. On October 1, 2023, at 10:29 a.m. LALD/CNS-A stated that they did not complete R3's discharge summary prior to start of survey and had completed on September 29, 2025, after surveyor requested R3's information. Licensee's Discharge Summary and Plan policy dated October 2022, read "the discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident." No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120	01530			

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01530	Continued From page 13 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation 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 staff received eight hours of initial dementia care training within the first 160 working hours of	01530			

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01530	Continued From page 14 employment for direct care staff as required for one of one employee (unlicensed personnel (ULP)-B). Additionally, the licensee failed to ensure direct care staff complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of one employee (ULP-B). 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) and was 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 the residents). The findings include: ULP-B was hired on May 5, 2024, and began providing assisted living services to residents. On September 29, 2025, at 10:58 a.m. surveyor observed ULP-B provide medication administration to residents. ULP-B's employee record contained documentation of 3.75 hours of dementia care training dated December 11, 2024. ULP-B's employee record lacked any additional dementia care training as well as mental health training. On September 30, 2025, at 2:18 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "I am unable to find anything in ULP-B's training from prior to AL regarding mental illness deescalating training." On September 30, 2025, at 2:55 p.m.	01530			

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01530	Continued From page 15 LALD/CNS-A stated "I do not unfortunately have any documentation of her dementia care training upon orientation. That is usually covered with our relias training and was not redone upon her orientation to the AL. I will have her complete them ASAP." On September 29, 2025, at 4:44 p.m. LALD/CNS-A stated "I spoke with our policy team, and we do not have a policy for formal dementia care however we do follow the MN regulations of 8 hours upon hire and 2 hours annually. They are also putting the mental illness training policy into effect and will have all staff complete ASAP." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods	01620			

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01620	Continued From page 16 based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01620			

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01620	Continued From page 17 (RN) completed a comprehensive assessment not to exceed 90 calendar days from the last assessment, for one of one resident (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 rib fracture, hypertension (high blood pressure), chronic back pain, dysphagia, restless leg syndrome, and depression. R2's Service Plan dated July 10, 2025, indicated R2 received services including bathing, grooming, hygiene, colostomy care, housekeeping, laundry, ambulation assist, mobility assist, and medication management. R2's most recent assessments were completed March 27, 2025, and July 10, 2025, indicating 106 days between assessments. On October 1, 2025, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had performed the resident's assessments and unsure the reason R2's assessments were past the required 90 day. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, read	01620			

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01620	Continued From page 18 "ongoing resident reassessment and monitoring must be conducted and cannot exceed 90 calendar days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
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	01650			

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01650	Continued From page 19 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 the service plan included 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 was 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 was admitted on April 25, 2025, and began receiving assisted living services. R1's Service Plan dated May 2, 2025, indicated R1 received services for oxygen as needed, mobility as needed, blood glucose, bathing, grooming, hygiene, dressing, housekeeping, laundry and medication management. R2 R2 was admitted on December 27, 2024, and began receiving assisted living services. R2's Service Plan dated July 10, 2025, indicated R2 received services including bathing, grooming, hygiene, colostomy care, housekeeping, laundry, ambulation assist,	01650			

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01650	Continued From page 20 mobility assist, and medication management. R1 and R2's service plan lacked the following: - 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. On October 1, 2025, at 10:41 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they will coordinate with their computer system to allow the service plan to include all required information. The licensee's 6.08 Service Plan policy dated August 1, 2021, read "the service plan would include a description of the services that are to be provided based on the most recent assessment and resident preference and fees for services provided." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Glenoaks Senior Living Campus
102 Glenoaks Drive
New London, MN 56273
Kandiyohi County
Parcel:

Phone:

License Info

License: HFID 2030

Risk:
License:
Expires on:
CFPM: Traci Dengerud
CFPM #: 106953; Exp: 2/5/2027

Inspection Info

Report Number: F7930251118
Inspection Type: Full - Single
Date: 9/29/2025 Time: 11:12:06 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: LIKE STATED ABOVE TO USE WITH APPROVED SANITIZING SOLUTION.

Comply By: 10/6/2025 Originally Issued On: 9/29/2025

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114E *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805E Provide and maintain a chemical sanitizer other than chlorine, iodine or a quaternary ammonium compound according to the US EPA registered label use instructions.

COMMENT: AT TIME OF INSPECTION A SPRAY BOTTLE OF DISINFECTANT/SANITIZER WAS ON SITE (IT WAS NOT CHLORINE, QUATERNARY AMMONIA OR LACTIC ACID). PROVIDE AN APPROVED SANITIZER LIKE CHLORINE, QUATERNARY AMMONIA OR LACTIC ACID TO SANITIZE SURFACES IN THE KITCHEN.

Comply By: 9/29/2025 Originally Issued On: 9/29/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: THE FIRE EXTINGUISHER WAS LAST TAGGED APRIL 2024. TAG YEARLY.

Comply By: 10/29/2025 Originally Issued On: 9/29/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F7930251118 from 9/29/2025

Establishment Representative

Tina Remmele,
Public Health Sanitarian 3
320-223-7302
tina.remmele@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

Glenoaks Senior Living Campus
New London
County/Group: Kandiyohi County

Inspection Info

Report Number: F7930251118
Inspection Type: Full
Date: 9/29/2025
Time: 11:12:06 AM

New Record: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: Upright Cooler at 38 Degrees F.

Comment:

Violation Issued?: No