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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: E3HQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00474

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245402**
2.STATE VENDOR OR MEDICAID NO.
(L2) **938342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/24/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Miriam Thornquist, HFE NEII — 04/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/05/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/13/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2015
(L33)

DETERMINATION APPROVAL

CCN: 24 5402

A Post Certification Revisit (PCR) was completed on April 24, 2015 to verify correction of deficiencies not in compliance at the time of the March 19, 2015 PCR. Based on our revisit, we have determined the deficiencies to be corrected as of April 7, 2015. As a result of this visit, we discontinued the Category 1 remedy of State monitoring as of April 7, 2015. In addition, we recommended to the CMS Region V Office, the following action outlined in our letter of April 30, 2015. CMS concurred and authorized this Department to notify the facility of the following:

- Mandatory Denial of payment for new Medicare and Medicaid Admissions (DPNA) effective May 4, 2015. (42 CFR 488.417 (b))

Since DPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP that was to begin, May 4, 2015.

Effective April 7, 2015, the facility is certified for 64 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

Certified Mail # 7013 2250 0001 6357 0051

April 28, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

RE: Project Number S5402025

Dear Ms. Krueger:

On April 24, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on April 24, 2015, imposed a daily fine in the amount of $300.00.

On April 24, 2015, a written notification was received by the Department stating that the violation(s) had been corrected. A reinspection was held on April 24, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is attached.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $34.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $334.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File
Gail Anderson, Fergus Falls District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

OrigRevisitLicPATALtr

MINNESOTA MDH DEPARTMENT of HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On April 24, 2015,

I, Mary S. Krueger (Name)(Please Print), Administator (Title)(Please Print), received the Notice of Penalty Assessment dated and licensing orders issued to:

Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

The Penalty Assessments and licensing orders attached hereto have been corrected as of April 24, 2015.

Signed: Mary Krueger (Name)(Please Print), Administrator (Title)(Please Print), Date 4/24/15

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On April 24, 2015,

I, Miriam Thorquist (Name)(Please Print), R.N. HFE II (Title)(Please Print), of the Division of Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:

Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

The Notice of Penalty Assessment was handed to Mary Krueger (Name)(Please Print), Adminstrator C.E.O. (Title)(Please Print), Date 4/24/15

Signed: Miriam Thorquist (Name)(Please Print), R.N. HFE II (Title)(Please Print), Date 4/24/15

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245402

May 5, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

Dear Ms. Krueger:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 7, 2015 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 30, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

RE: Project Number S5402025

Dear Ms. Krueger:

On March 27, 2015, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective April 1, 2015. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 4, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of March 27, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 4, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on February 4, 2015 , and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 19, 2015. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 24, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 19, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 7, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 19, 2015, as of April 7, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 7, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 27, 2015.

The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 4, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 4, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 4, 2015, is to be rescinded.

In our letter of March 27, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 4, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 7, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245402	A. Building B. Wing	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0441** Reg. # **483.65** LSC	**04/07/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/30/2015	31593	04/24/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/4/2015			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00474	A. Building B. Wing	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	**04/07/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/28/2015	31593	04/24/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/4/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: E3HQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00474

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245402**
2.STATE VENDOR OR MEDICAID NO.
(L2) **938342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Patricia Bernstetter, HFE NEII 04/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/29/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/07/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2015 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5402

A Post Certification Revisit (PCR) was completed on March 13, 2015 to verify correction of deficiencies issued pursuant to the standard survey completed on February 4, 2015. Surveyors determined the following deficiency was not corrected:

F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

As a result of this visit, we imposed the Category 1 remedy of State monitoring, effective April 1, 2015.

In addition, we recommended to the CMS Region V Office, the following remedy. CMS concurred and authorize this Department to notify the faciltiy of the follwing:

¿ Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 4, 2015. (42 CFR 488.417 (b))

If denial of payment goes into effect, the facility would be subject to a two year loss of NATCEP beginning May 4, 2015.

Refer to the CMS 2567b and CMS 2567 along with the facility's plan of correction. PCR to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7327

March 27, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

RE: Project Number S5402025

Dear Ms. Krueger:

On February 19, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 19, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 4, 2015. The deficiencies not corrected is as follows:

F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective April 1, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 4, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 4, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 4, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Glenwood Village Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective May 4, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: pam.kerssen@state.mn.us

Telephone: (218) 308-2129
Fax: (218) 308-2122

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5402r1_15

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on April 24, 2015.

April 24, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

Re: Project # S5402025

Dear Ms. Krueger:

On March 19, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 4, 2015 with orders received by you on February 24, 2015.

State licensing orders issued pursuant to the last survey completed on February 4, 2015 and found corrected at the time of this March 19, 2015 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on February 4, 2015, found not corrected at the time of this March 19, 2015 revisit and subject to penalty assessment are as follows:

21375 -- S/S: -- MN Rule 4658.0800 Subp. 1 -- Infection Control; Program - $300.00

The details of the violations noted at the time of this revisit completed on March 19, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of **$300.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: pam.kerssen@state.mn.us

Telephone: (218) 308-2129
Fax: (218) 308-2122

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	R 03/19/2015

RECEIVED
APR 13 2015
Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 3/19/15, to determine compliance with federal deficiencies issued during a recertification survey exited on 2/4/15. During this visit the following regulations were determined to be not corrected: F441	{F 000}		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	{F 441}		

Approved
4/14/15
SB

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

Mary L Krueger | Administrator/CEO | 4-8-2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	R 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 1 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 58 residents who resided in the facility. Findings include: The facility's Infection Control Logs were reviewed from 3/11/15, through 3/19/15. The logs identified tracked only residents with infections for which antibiotics were prescribed. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, specific symptoms that were present, cultures performed/ organism identified, and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified. During interview on 3/19/15, at 10:20 a.m. registered nurse (RN)-A confirmed that she does not have any documentation to support tracking or trending of infections within the facility except for charting a progress note in the computer system (point click care). During follow up interview at 3:03 p.m. RN-A verified she was told to report all infections to the director of nursing (DON) , because she was taking over infection	{F 441}	F441 It is the policy of Glenwood Village Care Center to monitor all residents and employees for signs/symptoms of infection. Infections will be tracked throughout the facility. All nursing units will have an infection control log that will be updated daily by the clinical managers. This information will also be shared at the daily IDT (Interdisciplinary team) meeting to monitor for trends.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	R 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 2 control and stated, "No education was really given." During interview on 3/19/15, at 10:31 a.m. RN-B confirmed that she does not have any documentation to support tracking or trending of infections within the facility except for charting a progress note in the computer system (point click care). During follow up interview at 3:10 p.m. RN-B verified she was not given any education on infection control and stated, "No I did not receive any education in regards to tracking and trending infections." RN-B also verified she was not sure who was currently tracking and trending infections within the building right now. During interview on 3/19/14, at 1:08 p.m. DON confirmed she did not have any further documentation to support tracking, trending, analysis or investigation of infections within the facility and stated, "I do not feel that I am tracking and trending these infections like I should be." Review of the facility policy titled, Infection Control GVCC Surveillance, dated 3/15 indicated the facility would closely monitor all residents who exhibit signs/symptoms of infection through ongoing surveillance and has systemic method of collecting, consolidating and analyzing data concerning the frequency and cause of a given disease or event. The intent of surveillance is to identify possible clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner.	{F 441}	All employee infections will be monitored on a daily basis by the Director of Nursing. The infection control log has been revised to document the comprehensive surveillance. It will document the location of the resident, record symptoms, identify cultures performed & organism that was identified and the date the infection was resolved. Antibiotic use related to the infection will also be tracked. The log will assist in the identification of any developing patterns. Compliance will be sustained by reviewing infection control logs weekly at the IDT meeting. Person Responsible: Director of Nursing Corrective Action Completed: April 7, 2015	

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245402	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/06/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0372** Reg. # **483.35(i)(3)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/06/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/mm	03/27/2015	33563	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/4/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	R 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 3/19/15. During this visit it was determined that the following correction order #1375 was NOT corrected. This uncorrected order will remain in effect and will be reviewed at the next site visit. To be reviewed for possible penalty assessment.	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	R 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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
{2 000}	Continued From page 1	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 2/19/15, will	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	R 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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
{21375}	Continued From page 2 remain in effect. Penalty Assessment Issued. Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 58 residents who resided in the facility. Findings include: The facility's Infection Control Logs were reviewed from 3/11/15, through 3/19/15. The logs identified tracked only residents with infections for which antibiotics were prescribed. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, specific symptoms that were present, cultures performed/ organism identified, and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified. During interview on 3/19/15, at 10:20 a.m. registered nurse (RN)-A confirmed that she does not have any documentation to support tracking or trending of infections within the facility except for charting a progress note in the computer system (point click care). During follow up interview at 3:03 p.m. RN-A verified she was told to report all infections to the director of nursing (DON) , because she was taking over infection control and stated, "No education was really given." During interview on 3/19/15, at 10:31 a.m. RN-B confirmed that she does not have any documentation to support tracking or trending of infections within the facility except for charting a progress note in the computer system (point click care). During follow up interview at 3:10 p.m. RN-B verified she was not given any education on infection control and stated, "No I did not receive any education in regards to tracking and trending	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	R 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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
{21375}	Continued From page 3 infections." RN-B also verified she was not sure who was currently tracking and trending infections within the building right now. During interview on 3/19/14, at 1:08 p.m. DON confirmed she did not have any further documentation to support tracking, trending, analysis or investigation of infections within the facility and stated, "I do not feel that I am tracking and trending these infections like I should be." Review of the facility policy titled, Infection Control GVCC Surveillance, dated 3/15 indicated the facility would closely monitor all residents who exhibit signs/symptoms of infection through ongoing surveillance and has systemic method of collecting, consolidating and analyzing data concerning the frequency and cause of a given disease or event. The intent of surveillance is to identify possible clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise policies and procedures related to components of the infection control program and develop a monitoring system to ensure compliance. Time Period For Correction: Twenty one- (21) days.	{21375}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00474	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**03/06/2015**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp. 4** LSC	**03/06/2015**	ID Prefix **21200** Reg. # **MN Rule 4658.0680 Subp. 6 A-I** LSC	**03/06/2015**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	**03/19/2015**	ID Prefix **21600** Reg. # **MN Rule 4658.1335 Subp. 2** LSC	**02/06/2015**	ID Prefix **21735** Reg. # **MN Rule 4658.1420** LSC	**02/09/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/mm	04/24/2015	33563	03/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/4/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E3HQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00474

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245402**

2.STATE VENDOR OR MEDICAID NO.
(L2) **938342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/04/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 03/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/24/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2453

February 19, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

RE: Project Number S5402025

Dear Ms. Krueger:

On February 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 16, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 16, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5402s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning assistance as directed by the care plan for 1 of 2 residents (R19) in the sample reviewed for positioning. Findings include: R19's quarterly Minimum Data Set dated 12/30/2104, indicated R19 was at risk for pressure related ulcers.	F 282	F282 It is the policy of the facility to have services provided by qualified persons trained to follow the resident's written plan of care. R19 routinely refuses repositioning when in his wheelchair. A referral has been made to OT to assess wheelchair positioning. Nursing Assistants have been retrained about the need to follow the plan of care and offer repositioning as outlined. Resident refusal must be documented.	3.16.15 OK

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary A Krueger | TITLE: CEO | (X6) DATE: 3/5/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 1 R19's care plan last revised 1/29/2015, indicated R19 had an alteration in skin integrity, required staff assistance to reposition and directed staff to reposition R19 every two hours. The care plan also indicated R19 had a history of refusing repositioning and directed staff to encourage R19 to reposition. On 2/3/15, from 11:48 a.m. until 3:03 p.m. R19 was continuously observed seated in the wheelchair (3 hours and 45 minutes) without repositioning. On 02/03/2015, at 2:54 p.m. nursing assistant (NA)-A stated she was assigned to R19 from 6:30 a.m. to 3:00 p.m. NA-A stated she was not sure what repositioning directive was on R19's care plan but was sure R19 was to be repositioned every 2 hours at night. NA-A stated R19 had not been repositioned since 7:18 a.m. (7 hours and 36 minutes) this morning and verified R19 had not been offered nor refused repositioning assistance. On 2/04/2015, at 9:01 a.m. NA-C who also worked with R19 on 2/3/15, stated staff were supposed to reposition R19 every 2-3 hours. NA-C also stated R19 had not been assisted out of his wheelchair during the day shift on 2/3/15. On 02/04/2015, at 2:12 p.m. registered nurse (RN)-B confirmed R19's care plan and stated R19 was to be repositioned every two hours as directed.	F 282	Random Audits will be conducted on repositioning x4 weeks. Audits will be shared at Quality Assurance for review and compliance. Responsible Person: Director of Nursing. Corrective Action Completed by: 3/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 2 On 02/04/2015, at 4:11 p.m. RN-B stated she would expect staff to reposition R19 every 2 hours as directed. Review of the facility policy titled Resident Care Plans indicated the purpose of Resident Care Plans was to provide continual care, comprehensive assessment of resident's strengths, problems, needs and how they are to be met and evaluated.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents identified at risk for pressure ulcers received positioning assistance in order to prevent the development of pressure ulcers for 1 of 2 residents (R19) in the sample identified at risk for pressure ulcers. Findings include:	F 314	F314 It is the facility policy that based on the comprehensive assessment of a resident to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable and that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	

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F 314	Continued From page 3 R19's current Physicians Order Summary Report last updated 1/29/2015, indicated R19 was diagnosed with dementia, diabetes, depression, weakness, urinary incontinence, constant dermatitis, generalized muscle weakness, contact dermatitis, eczema and inflammatory disorder male genital organs. R19's admission Minimum Data Set (MDS) dated 10/9/2014, and quarterly MDS dated 12/30/2104, both indicated R19 had severe cognitive impairment, utilized a urinary catheter, was frequently incontinent of bowel, was at risk for pressure ulcers and required extensive staff assistance with all activities of daily living (ADLs), except for eating. R19's care plan last revised 1/29/2015, indicated R19 had an alteration in skin integrity related to advanced age, decreased mobility, incontinence, diabetes and inconsistent repositioning. The care plan indicated R19 utilized a pressure reducing mattress, pressure reducing wheelchair cushion and directed staff to reposition R19 every two hours. The care plan identified R19 had a history of refusing repositioning, and directed staff to encourage R19 to reposition. The nursing Kardex (Nursing Assistant Care Sheet) for R19, dated 1/5/2015, indicated R19 was to be repositioned every 2 hours. R19's physician orders included: dimethicone cream to head of penis every day and evening	F 314	A comprehensive skin assessment has been completed for R19 and care plan updated. R19 continues to refuse to be repositioned when sitting in his wheelchair, allowing staff to assist him to bathroom and bed. Policy was reviewed with RN staff in regard to comprehensive skin assessments . Nursing Assistants have been retrained about the need to follow the plan of care and offer repositioning as outlined. Audits will be conducted on all new admissions x 4 weeks for comprehensive skin assessments. Audits will be conducted on new open areas for comprehensive skin	

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F 314	Continued From page 4 shift since 1/29/15, A&D ointment to groin, buttocks and scrotum to prevent skin breakdown every day and evening shift since 1/23/15, to keep off bottom as much as possible since 12/14/14, lamisilat cream to groin, twice per day as needed since 10/2/14, ketoconazole gel to scrotum three times per day since 1/6/15, and ceftin for penis ulcer infection for 10 days since 2/2/15. Review of R19's nursing progress notes from 10/7/2014, to 2/3/201,5 revealed the following: -On 12/19/14, indicated R19's monthly care plan review was completed and indicated R19's care plan remained appropriate. -On 1/17/2015, indicated R19 did not want to lay in bed to relieve pressure / assist in healing his sore bottom but agreed after encouragement. -On 1/18/2015, indicated little improvement noted on his bottom, was still red and sore. -On 1/30/2015, indicated R19 was provided evening cares and skin treatments. The note also indicated A & D Ointment was applied to the buttocks and an open area with bleeding was noted on the left buttock cheek. On 2/3/15, from 11:48 a.m. until 3:03 p.m. R19 was continuously observed seated in the wheelchair (3 hours and 45 minutes) without repositioning. On 02/03/2015, at 2:54 p.m. nursing assistant	F 314	assessments x4 weeks. Audits will be shared at Quality Assurance for review and compliance. Responsible Person: Director of Nursing. Corrective Action Completed by: 3/6/15	

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F 314	Continued From page 5 (NA)-A stated she was assigned to care for R19 from 6:30 a.m. to 3:00 p.m. NA-A stated she was not sure what repositioning directive was on R19's care plan but was sure R19 was to be repositioned every 2 hours at night. NA-A stated R19 had not been repositioned since 7:18 a.m. (7 hours and 36 minutes) this morning and verified R19 had not been offered nor refused repositioning assistance. On 2/04/2015, at 9:01 a.m. NA-C who also worked with R19 on 2/3/15, stated staff were supposed to reposition R19 every 2-3 hours and felt staff could get him off his bottom more than that. NA-C also stated R19 has had different skin issues for the last 6 months. NA-C also confirmed R19 was not assisted / repositioned out of his wheelchair during the day shift on 2/3/15, for 7 hours and 36 minutes. On 02/04/2015, at 2:12 p.m. registered nurse (RN)-B confirmed R19's long standing skin conditions and risk there of and verified R19's care plan and stated R19 was to be repositioned every two hours as directed. RN-B stated she was not aware of R19 refusing repositioning and if so, staff were supposed to document the refusals in the computer. On 02/04/2015, at 4:11 p.m. RN-B stated she would expect staff to reposition R19 every 2 hours as directed and document if refused. Review of the facility policy titled Turning and Repositioning (Tissue Tolerance) Observation	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 6 Policy and Procedure, dated 3/04, indicated once an individualized turning an repositioning schedule was determined the resident would be turned every 2 hours or more often according to individual needs and to assist resident and to teach staff to make small changes in position to alter pressure points every 30 minutes while up, use different chairs alternately and if resident was non-compliant with repositioning it would be reflected on their care plan.	F 314	**F356:**	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	It is the policy of Glenwood Village Care Center to post actual daily staffing hours daily at the beginning of each shift. The following information will be posted facility name, current date, and total number of actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: registered nurses; licensed practical nurses; certified nurse aides and resident census. The following information will be posted on a daily basis. The form will continue to be posted in a visible area for residents, staff, visitors, etc to review.	

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	245402	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

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F 356	Continued From page 7 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing hours posting was updated daily to reflect current hours worked. This had the potential to affect all 59 residents who resided in the facility and family / visitors who wished to view this information. Findings include: During the initial tour on 2/1/15, at 9:22 a.m. the nursing hours posting was observed in a plastic sleeve, secured to a wall, directly across from the reception desk in the facility's main lobby. The posting included the current resident census, facility name, date, hours of labor and each shift of work for registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs). However, the posting was dated 1/30/15, and was not updated to reflect the hours worked on 2/1/15. During subsequent observations of the nursing hours posting, the following was identified: On 2/1/15, at 4:10 p.m. nursing hours posting was dated 1/30/15, and was not updated to reflect the hours worked on 2/1/15. On 2/2/15, at 7:00 a.m. and again at 2:30 p.m., nursing hours posting was dated 1/30/15, and	F 356	Daily nursing staffing posting policy was reviewed and remains appropriate. Weekend schedules will be posted late Friday and laid side by side so that each day may be seen without lifting any pages. Audits will be conducted weekly x4 to make sure form is filled out correctly. Audits will be brought to the quality assurance for compliance and review. Licensed staff and nursing scheduler will be educated on the policy by March 6, 2015. Responsible Person: Director of Nursing	

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F 356	Continued From page 8 was not updated to reflect the hours worked on 2/2/15. On 2/3/15, at 9:29 a.m. nursing hours posting was dated 1/30/15, and was not updated to reflect the hours worked on 2/3/15. During interview on 2/4/15, at 9:27 a.m. the director of nursing (DON) confirmed the facility's receptionist was responsible for updating the nursing hours posting on weekdays and the charge nurse was responsible for updating the posting on weekends. The DON verified the staff posting should have been updated daily. The DON added, "I would expect her (the charge nurse) to keep the posting up to date." The facility's Posting Daily Nursing Staff Schedule policy dated 12/10, indicated the facility was to post the number of nursing personnel responsible for providing direct care to residents, for each shift, on a daily basis.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 It is the facility policy to procure food from approved sources and to store, prepare, distribute and serve food under sanitary conditions.	

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F 371	Continued From page 9 by: Based on observation, interview and document review, the facility failed to ensure food preparation equipment was properly sanitized between each use, to prevent food borne illness. This had the potential to affect 59 of 59 residents who ate in the facility. Findings include: During the initial kitchen tour on 2/1/15, at 9:15 a.m. dishes and utensils were observed on a drying mat, atop the stainless steel counter, attached to the two-compartment sink. Cook (C)-A stated that she prepared and cooked all of the entrees, vegetables, ground foods, puree foods, cold salads and desserts for resident meals. C-A stated that she washed pots, pans, bowls, spatulas, whisks and any other food preparation equipment that they used more than once per day, in the two-compartment sink. C-A stated she washed the equipment with Dawn dish soap, rinsed them off with hot water and allowed them to air dry on the drying mat. C-A stated these items were then either re-used or put away, to be used by other dietary staff. C-A stated she did not know how the water temperature was monitored for rinsing the equipment she washed in the two-compartment sink. C-A stated she had never measured the temperature of the rinse water, and confirmed there was no record for measuring the rinse water temperature. During observation of meal preparation on 2/2/15, at 9:35 a.m. a spatula was lying on the drying mat, next to the two-compartment sink. C-B stated that she did not generally wash and re-use	F 371	The dietary manager has educated all cooks about sanitizing all dishes and utensils in between uses to ensure proper sanitation. On 3/5/15 an additional memo of education was attached to all dietary employee's paychecks to ensure they received the information on proper sanitation. Random observations will be made x4 weeks and reported to the Quality Assurance Committee. Person Responsible: Dietary Manager Corrective Action Completed by: 3/6/15	

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F 371	Continued From page 10 utensils and bowls using the two-compartment sink. On 2/4/15, at 8:26 a.m. the dietary manager reported it was her expectation that the facility cooks sent all dishes and utensils through the dish machine, after each use. The dietary manager confirmed C-A and C-B were re-using food preparation utensils and equipment, after only washing them with Dawn dish soap and rinsing them under hot water in the two-compartment sink, without sending them through the dish machine. The dietary manager stated that she educated C-A, C-B and C-C not to re-use equipment and to send all dishes and equipment through the dish machine to ensure proper sanitization. The facility's Dish Machine Policy dated 5/13, identified all small-wares, silverware and any pots/ pans were to be cleaned and sanitized using the commercial dish machine, with a minimum, final hot water rinse temperature of 180 degrees Fahrenheit (F), for proper sanitization.	F 371		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure outside storage receptacles were maintained in a manner which contained the refuse, thereby preventing overflow and keeping the grounds free from litter and	F 372	F372 It is the policy of the facility to dispose of garbage and refuse properly.	

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F 372	Continued From page 11 trash. This had the potential to affect all 59 residents who resided in the facility. Findings include: During observation on 2/2/15, at 7:10 a.m. the facility's dumpster area included three- large, blue dumpsters, located to the West-side of the nursing home, near the curb and street. The attached dumpster covers to the first and second dumpster units (closest to the street) were pushed up, approximately three to four feet, by white/clear garbage bags heaping from the receptacles. Both dumpster units were overfilled with trash bags. One white/clear bag full of trash was observed on the street, with vehicles parked in front of it. On 2/2/15, at 8:16 a.m. Maintenance (M)-A and M-B provided a tour of the facility's dumpster area. M-A stated the dumpsters were emptied at Noon, on Mondays and Thursdays by a sanitation company. M-A was noted to pick up the trash bag that was lying in the street and placed it into one of the overfilled dumpsters. M-B stated the dumpsters became full after the weekend and they could not control the volume of trash, or the trash that lay on the ground, as the sanitation company spilled bags when they emptied the units. M-B added, people who lived in town added their trash to the facility's dumpsters, which were also to be used for an assisted living facility and other housing units that were owned by the same company. M-B reported some campground garbage was emptied there as well. The facility's undated Garbage Procedure, failed	F 372	Internal garbage procedures were reviewed and revised by the Director of Plant Operations. Dumpsters will be emptied on Mondays and Thursdays. Maintenance will monitor daily and call for additional pickup if needed. Maintenance will also monitor the surrounding area daily and make sure plastic lids are closed, Person Responsible: Director of Plant Operations. Corrective Action Completed: 2/9/15	

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F 372	Continued From page 12 to address garbage overflow and procedures to keep the grounds free of litter or trash.	F 372		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 It is the policy of the facility to be in compliance with all aspects of F431 and to ensure that all drugs and biologicals are labeled in accordance with currently accepted professional principles that include the appropriate accessory and cautionary instructions and the expiration date when applicable. Upon discovery of expired drugs in the ER kit, corrective action was taken immediately. Trumm Drug changed out the Emergency kit immediately. To prevent further problems, each kit will have an expiration date attached to the lid corresponding to the medication in the kit that is due to expire next. The kits will be checked at each medication exchange between Trumm Drug and the nursing facility.	

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F 431	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to routinely evaluate emergency supply medications for expiration, removing expired medications from available use. This affected 1 of 1 resident (R12) who was administered antibiotic medications that had expired and had the potential to affect all 59 residents who were eligible to receive medications from the facility's emergency supply. Findings include: On 2/3/15, at 1:11 p.m. the Station-One medication cart was reviewed with registered nurse (RN)-A. One of the medication bottles was labeled Cipro (an antibiotic) 500 milligrams (mg), five tablets, with three tablets observed as remaining in the bottle. The label identified the medication had expired on 1/15. RN-A identified the expired medication was obtained from the facility's emergency medication supply. The facility's Emergency Kit log was reviewed and identified the bottle of Cipro was signed out for R12 on 2/1/15 (post expiration date), for a diagnosis of urinary tract infection. RN-A confirmed R12 had been administered four doses of one-half tablet (250 mg) each, of the expired Cipro from 2/1/15, to 2/3/15. A thorough review of the facility's emergency medication supply was then conducted with RN-A, with additional expired medications identified, including the following: Two vials of Morphine Sulfate (a pain medication) 10/mg/ml (milliliter)/ inj (injection), expired 1/1/15; Two vials of Benadryl (an antihistamine medication) 50 mg/ml/inj, expired 11/14; Four vials of Lasix (a diuretic medication) 10	F 431	The pharmacy will maintain a logbook that contains the following: 1.) Date the kit was returned 2.)Date the kit was replenished 3.)initials of the technician and pharmacist who replenished 4.) the expiration date of the kit 5.) the number of the padlock seal. Person Responsible: Director of Nursing Corrective Action Completed: 2/6/15	

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F 431	Continued From page 14 mg/ml/inj, expired 11/1/14; Two vials of Glucagon (a medication used to treat very low blood sugar), expired 10/14; Two vials of Haldol (an antipsychotic medication) 5 mg/ml/inj, expired 12/14; One bottle of Nitrostat 1/150 grain (a vasodilator medication which increased oxygen and blood flow to the heart) 0.4 mg tablets, expired 11/14; Five vials of Xylocaine (a local anesthetic) 1%, 10 mg/ml/inj, expired 1/15; and One bottle of Zithromax (an antibiotic medication), six tablets, expired 11/14. During interview on 2/3/15, at 2:43 p.m. the pharmacy technician reported emergency supply medications were labeled with expiration dates, as deemed by the manufacturer of each medication. The pharmacy technician verified the bottle of Cipro tablets administered to R12 had expired. During interview on 2/3/15, at 2:50 p.m. the director of nursing (DON) expressed surprise over expired medications in the emergency supply. The DON added, "[Pharmacy personnel] just went through it." During interview on 2/3/15, at 5:19 p.m. a pharmacist from the facility's supplying pharmacy indicated the usual practice was to review expiration dates of all medications in the emergency supply box whenever a medication was replaced after facility use. The facility's Emergency Drug Box policy revised 1/15, identified the pharmacy which owned the emergency medication supply, was responsible for removing any drug that was outdated.	F 431		

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F 441 F 441 SS=F	Continued From page 15 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	**F441** It is the intent of the facility to have an infection control program that provides for a safe, sanitary and comfortable environment that prevents the development and transmission of disease and infection. The control log will be redesigned to track all components including location, symptoms, cultures and organisms identified, antibiotics used and resolution. Analysis of infections will also be a part of the surveillance. RN's in facility will be inserviced on the components of the infection control program. Person Responsible: Director of Nursing Corrective Action Completed: 3/11/15	

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 59 residents who resided in the facility. Findings include: The facility's Infection Control Log(s) were reviewed from 6/14, through 2/15. The logs identified and tracked only residents with infections for which antibiotics were prescribed. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, specific symptoms that were present, cultures performed/ organism identified, specific antibiotic used, and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified. During interview on 2/4/15, at 1:30 p.m. the infection control coordinator (ICC) confirmed she did not have any further documentation to support tracking or trending of infections with in the facility. During a follow up interview at 1:56 p.m., ICC stated, "I only monitor antibiotic use in the facility for now." The ICC verified that effectively, no infection control program of surveillance/ analysis/ investigation was being implemented within the facility, but confirmed it should have been. On 2/4/15, at 2:20 p.m. the director of nursing (DON) confirmed she did not have any further documentation to support tracking, trending,	F 441		

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F 441	Continued From page 17 analysis or investigation of infections with in the facility. The DON verified it was her expectation for staff to track infections within the building. The DON stated, "We are just cleaning surfaces and just tracking antibiotic use right now." A policy which directed the procedures and responsibilities of the facility's infection control program was requested, but was not provided.	F 441		

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	245402	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Glenwood Village Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Glenwood Village Care Center was constructed at four different times. The original building was built in the 1962, is 1- story, with a partial basement and was determined to be of a Type II (111) construction. In 1975 an addition was added to the northeast that was determined to be Type II (111) construction. In 1978 an addition was added to the southeast that was determined to be Type II (111) construction. In 1987 an addition was added to the west that was determined to be Type II(111). In 2014 the 1987 addition was renovated into a 15 bed southwest wing. Type II (III) construction. The building is divided into 6 smoke zones on the main floor. An automatic sprinkler system is installed throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces. Also, the facility has battery powered smoke detection in all resident sleeping rooms. The fire alarm is monitored for automatic fire department	K 000		

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

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

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	245402	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2015**

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GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET** **GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 notification. Because the original building and the 3 additions are of the same type of construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a capacity of 64 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is METas evidenced by:	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2453

February 19, 2015

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5402025

Dear Ms. Krueger:

The above facility was surveyed on February 1, 2015 through February 4, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at the number or email listed above.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s) 5402s15lic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	02/04/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 1, 2, 3 and 4, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program, Gail Anderson, Unit Supervisor, 1505 Pebble Lake Road, Suite 300, Fergus Falls, 56537.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning	2 565		

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2 565	Continued From page 2 assistance as directed by the care plan for 1 of 2 residents (R19) in the sample reviewed for positioning. Findings include: R19's quarterly Minimum Data Set dated 12/30/2104, indicated R19 was at risk for pressure related ulcers. R19's care plan last revised 1/29/2015, indicated R19 had an alteration in skin integrity, required staff assistance to reposition and directed staff to reposition R19 every two hours. The care plan also indicated R19 had a history of refusing repositioning and directed staff to encourage R19 to reposition. On 2/3/15, from 11:48 a.m. until 3:03 p.m. R19 was continuously observed seated in the wheelchair (3 hours and 45 minutes) without repositioning. On 02/03/2015, at 2:54 p.m. nursing assistant (NA)-A stated she was assigned to R19 from 6:30 a.m. to 3:00 p.m. NA-A stated she was not sure what repositioning directive was on R19's care plan but was sure R19 was to be repositioned every 2 hours at night. NA-A stated R19 had not been repositioned since 7:18 a.m. (7 hours and 36 minutes) this morning and verified R19 had not been offered nor refused repositioning assistance.	2 565		

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2 565	Continued From page 3 On 2/04/2015, at 9:01 a.m. NA-C who also worked with R19 on 2/3/15, stated staff were supposed to reposition R19 every 2-3 hours. NA-C also stated R19 had not been assisted out of his wheelchair during the day shift on 2/3/15. On 02/04/2015, at 2:12 p.m. registered nurse (RN)-B confirmed R19's care plan and stated R19 was to be repositioned every two hours as directed. On 02/04/2015, at 4:11 p.m. RN-B stated she would expect staff to reposition R19 every 2 hours as directed. Review of the facility policy titled Resident Care Plans indicated the purpose of Resident Care Plans was to provide continual care, comprehensive assessment of resident's strengths, problems, needs and how they are to be met and evaluated. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to care plan implementation. Pertinent employees could be re-educated on these policies. A system for evaluating and monitoring consistent care plan implementation could be developed, with the results of these audits being reviewed by the facility's Quality Assessment & Assurance committee.	2 565		

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2 565	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents identified at risk for pressure ulcers received positioning assistance in order to prevent the development of pressure ulcers for 1 of 2 residents (R19) in the sample identified at risk for pressure ulcers. Findings include: R19's current Physicians Order Summary Report last updated 1/29/2015, indicated R19 was diagnosed with dementia, diabetes, depression, weakness, urinary incontinence, constant dermatitis, generalized muscle weakness, contact dermatitis, eczema and inflammatory disorder male genital organs.	2 905		

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2 905	Continued From page 5 R19's admission Minimum Data Set (MDS) dated 10/9/2014, and quarterly MDS dated 12/30/2104, both indicated R19 had severe cognitive impairment, utilized a urinary catheter, was frequently incontinent of bowel, was at risk for pressure ulcers and required extensive staff assistance with all activities of daily living (ADLs), except for eating. R19's care plan last revised 1/29/2015, indicated R19 had an alteration in skin integrity related to advanced age, decreased mobility, incontinence, diabetes and inconsistent repositioning. The care plan indicated R19 utilized a pressure reducing mattress, pressure reducing wheelchair cushion and directed staff to reposition R19 every two hours. The care plan identified R19 had a history of refusing repositioning, and directed staff to encourage R19 to reposition. The nursing Kardex (Nursing Assistant Care Sheet) for R19, dated 1/5/2015, indicated R19 was to be repositioned every 2 hours. R19's physician orders included: dimethicone cream to head of penis every day and evening shift since 1/29/15, A&D ointment to groin, buttocks and scrotum to prevent skin breakdown every day and evening shift since 1/23/15, to keep off bottom as much as possible since 12/14/14, lamisilat cream to groin, twice per day as needed since 10/2/14, ketoconazole gel to scrotum three times per day since 1/6/15, and ceftin for penis ulcer infection for 10 days since 2/2/15.	2 905		

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2 905	Continued From page 6 Review of R19's nursing progress notes from 10/7/2014, to 2/3/201,5 revealed the following: -On 12/19/14, indicated R19's monthly care plan review was completed and indicated R19's care plan remained appropriate. -On 1/17/2015, indicated R19 did not want to lay in bed to relieve pressure / assist in healing his sore bottom but agreed after encouragement. -On 1/18/2015, indicated little improvement noted on his bottom, was still red and sore. -On 1/30/2015, indicated R19 was provided evening cares and skin treatments. The note also indicated A & D Ointment was applied to the buttocks and an open area with bleeding was noted on the left buttock cheek. On 2/3/15, from 11:48 a.m. until 3:03 p.m. R19 was continuously observed seated in the wheelchair (3 hours and 45 minutes) without repositioning. On 02/03/2015, at 2:54 p.m. nursing assistant (NA)-A stated she was assigned to care for R19 from 6:30 a.m. to 3:00 p.m. NA-A stated she was not sure what repositioning directive was on R19's care plan but was sure R19 was to be repositioned every 2 hours at night. NA-A stated R19 had not been repositioned since 7:18 a.m. (7 hours and 36 minutes) this morning and verified R19 had not been offered nor refused repositioning assistance.	2 905		

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2 905	Continued From page 7 On 2/04/2015, at 9:01 a.m. NA-C who also worked with R19 on 2/3/15, stated staff were supposed to reposition R19 every 2-3 hours and felt staff could get him off his bottom more than that. NA-C also stated R19 has had different skin issues for the last 6 months. NA-C also confirmed R19 was not assisted / repositioned out of his wheelchair during the day shift on 2/3/15, for 7 hours and 36 minutes. On 02/04/2015, at 2:12 p.m. registered nurse (RN)-B confirmed R19's long standing skin conditions and risk there of and verified R19's care plan and stated R19 was to be repositioned every two hours as directed. RN-B stated she was not aware of R19 refusing repositioning and if so, staff were supposed to document the refusals in the computer. On 02/04/2015, at 4:11 p.m. RN-B stated she would expect staff to reposition R19 every 2 hours as directed and document if refused. Review of the facility policy titled Turning and Repositioning (Tissue Tolerance) Observation Policy and Procedure, dated 3/04, indicated once an individualized turning an repositioning schedule was determined the resident would be turned every 2 hours or more often according to individual needs and to assist resident and to teach staff to make small changes in position to alter pressure points every 30 minutes while up, use different chairs alternately and if resident was non-compliant with repositioning it would be reflected on their care plan.	2 905		

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2 905	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could train all staff and perform audits to ensure each resident is receiving appropriate nursing care as directed by the individual care plan and initiate monitoring to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		
21200	MN Rule 4658.0680 Subp. 6 A-E Manual Cleaning and Sanitizing; Methods Subp. 6. Sanitization methods. The food-contact surfaces of all equipment and utensils must be sanitized by one of the following methods: A. immersion for at least one-half minute in clean, hot water at a temperature of at least 170 degrees Fahrenheit (77 degrees centigrade); B. immersion for at least one minute in a clean solution containing at least 50 parts per million, but no more than 200 parts per million, of available chlorine as a hypochlorite and at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade); C. immersion for at least one minute in a clean solution containing at least 12.5 parts per million, but not more than 25 parts per million, of available iodine and having a pH range which the manufacturer has demonstrated to be effective and at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade); D. immersion in a clean solution containing any other chemical sanitizing agent allowed under Code of Federal Regulations, title 21, section 178.1010, that will provide at least the equivalent	21200		

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21200	Continued From page 9 bactericidal effect of a solution containing 50 parts per million of available chlorine as a hypochlorite at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade) for one minute; or E. for equipment too large to sanitize by immersion, but in which steam can be confined, treatment with steam free from materials or additives other than those specified in Code of Federal Regulations, title 21, section 173.310. Equipment too large to sanitize by immersion must be rinsed, sprayed, or swabbed with a sanitizing solution of at least twice the required strength for that particular sanitizing solution. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food preparation equipment was properly sanitized between each use, to prevent food borne illness. This had the potential to affect 59 of 59 residents who ate in the facility. Findings include: During the initial kitchen tour on 2/1/15, at 9:15 a.m. dishes and utensils were observed on a drying mat, atop the stainless steel counter, attached to the two-compartment sink. Cook (C)-A stated that she prepared and cooked all of the entrees, vegetables, ground foods, puree foods, cold salads and desserts for resident meals. C-A stated that she washed pots, pans, bowls, spatulas, whisks and any other food	21200		

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21200	Continued From page 10	21200		

preparation equipment that they used more than once per day, in the two-compartment sink. C-A stated she washed the equipment with Dawn dish soap, rinsed them off with hot water and allowed them to air dry on the drying mat. C-A stated these items were then either re-used or put away, to be used by other dietary staff. C-A stated she did not know how the water temperature was monitored for rinsing the equipment she washed in the two-compartment sink. C-A stated she had never measured the temperature of the rinse water, and confirmed there was no record for measuring the rinse water temperature.

During observation of meal preparation on 2/2/15, at 9:35 a.m. a spatula was lying on the drying mat, next to the two-compartment sink. C-B stated that she did not generally wash and re-use utensils and bowls using the two-compartment sink.

On 2/4/15, at 8:26 a.m. the dietary manager reported it was her expectation that the facility cooks sent all dishes and utensils through the dish machine, after each use. The dietary manager confirmed C-A and C-B were re-using food preparation utensils and equipment, after only washing them with Dawn dish soap and rinsing them under hot water in the two-compartment sink, without sending them through the dish machine. The dietary manager stated that she educated C-A, C-B and C-C not to re-use equipment and to send all dishes and equipment through the dish machine to ensure proper sanitization.

The facility's Dish Machine Policy dated 5/13, identified all small-wares, silverware and any pots/ pans were to be cleaned and sanitized using the commercial dish machine, with a

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21200	Continued From page 11 minimum, final hot water rinse temperature of 180 degrees Fahrenheit (F), for proper sanitization. SUGGESTED METHOD OF CORRECTION: The food service director (FSD) could review and revise policies and procedures for proper use of the three compartment sink for sanitization purposes. In addition, the (FSD) or designated staff member could provide training for all involved staff and perform observational audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21200		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident symptoms, analysis of the surveillance and investigation of patterns identified. This had the potential to affect all 59 residents who resided in the facility. Findings include: The facility's Infection Control Log(s) were reviewed from 6/14, through 2/15. The logs	21375		

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	00474	A. BUILDING: _____ B. WING _____	02/04/2015

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21375	Continued From page 12 identified and tracked only residents with infections for which antibiotics were prescribed. The facility's surveillance processes also lacked identification of the following: location of the resident within the facility, specific symptoms that were present, cultures performed/ organism identified, specific antibiotic used, and the date the infection resolved. Furthermore, the logs lacked analysis and/or investigation of patterns identified. During interview on 2/4/15, at 1:30 p.m. the infection control coordinator (ICC) confirmed she did not have any further documentation to support tracking or trending of infections with in the facility. During a follow up interview at 1:56 p.m., ICC stated, "I only monitor antibiotic use in the facility for now." The ICC verified that effectively, no infection control program of surveillance/ analysis/ investigation was being implemented within the facility, but confirmed it should have been. On 2/4/15, at 2:20 p.m. the director of nursing (DON) confirmed she did not have any further documentation to support tracking, trending, analysis or investigation of infections with in the facility. The DON verified it was her expectation for staff to track infections within the building. The DON stated, "We are just cleaning surfaces and just tracking antibiotic use right now." A policy which directed the procedures and responsibilities of the facility's infection control program was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise policies and procedures related to components of the infection control program	21375		

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21375	Continued From page 13 and develop a monitoring system to ensure compliance. Time Period For Correction: Twenty one- (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all residents and health care workers (HCW's) received 2 step tuberculin skin test (TST) for 1 of 5 residents (R20) in the	21426		

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21426	Continued From page 14 sample and 1 of 5 newly hired employees, trained medical assistant (TMA)-A in the sample. Findings include: R20's 2nd step TST was not interpreted as required. R20 had been admitted to the facility on 1/9/15. After review of the record, a baseline screening was done for signs and symptoms of tuberculosis (TB) for R20 on 1/9/15. A TST was administered to R20 on 1/9/15 and a second step administered on 1/18/15, however the record lacked documentation of interpretation of the second step TST. A repeat of the TST was not given. In addition the facility lacked all components required for health care workers (HCW's) for a 2 step tuberculin skin test. TMA-A had been hired on 10/28/14. After review of the record, a baseline screening was done for signs and symptoms of TB for TMA-A on 12/3/14. A TST was administered to TMA-A on 10/28/15 and the results were not read within 72 hours, further more the form indicated (out of compliance start over). A TST was administered to TMA-A on 12/3/14 and a second step administered on 12/17/14, however the TMA-A had been working on the floor since 10/28/14 with no baseline screening or 2 step tuberculin skin test prior to working and continues to work on the floor. During interview on 2/4/15 at 11:30 a.m. medical	21426		

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21426	Continued From page 15 records personnel (MRP)-A confirmed staff were to record the results of the TST's in the computer and paper form if the TST was negative or positive and what the duration was. During interview on 2/4/15 at 11:43 a.m. the director of nursing (DON) confirmed the facility policy and indicated she expected staff to give residents a first step TST on the day of admission and second step TST 14 days later, then document results in he computer and on the paper form. The DON also verified all employees get their first TST on day of orientation and second TST 14 days later and stated "they are not allowed to work on the floor if we catch them." and "no I do not think this is good infection control practice, they should be given TST on hire and admission." Review of facility policy titled, TB Exposure Control Plan, revised 6/2012, refers to the facility will administer a two step TST to all residents upon admission and will be evaluated for symptoms of TB. The TST form will be filled out by administrating nurse. Administration date and read date will also be added to residents med sheets for step one and tow of TST. A TST will be performed on all employees, unless contraindicated, upon hire. Step one of TST will be administered and read before as employee can start work. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop a system to ensure the facility is maintaining an accurate system for recording Mantoux testing for resident and staff in order to	21426		

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21426	Continued From page 16 provide appropriate care and services. The Director of Nursing could develop and implement a random audit tool to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to routinely evaluate emergency supply medications for expiration, removing expired medications from available use. This affected 1 of 1 resident (R12) who was administered antibiotic medications that had expired and had the potential to affect all 59 residents who were eligible to receive medications from the facility's emergency supply. Findings include: On 2/3/15, at 1:11 p.m. the Station-One medication cart was reviewed with registered nurse (RN)-A. One of the medication bottles was labeled Cipro (an antibiotic) 500 milligrams (mg), five tablets, with three tablets observed as remaining in the bottle. The label identified the medication had expired on 1/15. RN-A identified	21600		

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21600	Continued From page 17	21600		

the expired medication was obtained from the facility's emergency medication supply. The facility's Emergency Kit log was reviewed and identified the bottle of Cipro was signed out for R12 on 2/1/15 (post expiration date), for a diagnosis of urinary tract infection. RN-A confirmed R12 had been administered four doses of one-half tablet (250 mg) each, of the expired Cipro from 2/1/15, to 2/3/15. A thorough review of the facility's emergency medication supply was then conducted with RN-A, with additional expired medications identified, including the following:

Two vials of Morphine Sulfate (a pain medication) 10/mg/ml (milliliter)/ inj (injection), expired 1/1/15;
Two vials of Benadryl (an antihistamine medication) 50 mg/ml/inj, expired 11/14;
Four vials of Lasix (a diuretic medication) 10 mg/ml/inj, expired 11/1/14;
Two vials of Glucagon (a medication used to treat very low blood sugar), expired 10/14;
Two vials of Haldol (an antipsychotic medication) 5 mg/ml/inj, expired 12/14;
One bottle of Nitrostat 1/150 grain (a vasodilator medication which increased oxygen and blood flow to the heart) 0.4 mg tablets, expired 11/14;
Five vials of Xylocaine (a local anesthetic) 1%, 10 mg/ml/inj, expired 1/15; and
One bottle of Zithromax (an antibiotic medication), six tablets, expired 11/14.

During interview on 2/3/15, at 2:43 p.m. the pharmacy technician reported emergency supply medications were labeled with expiration dates, as deemed by the manufacturer of each medication. The pharmacy technician verified the bottle of Cipro tablets administered to R12 had expired.

During interview on 2/3/15, at 2:50 p.m. the

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21600	Continued From page 18 director of nursing (DON) expressed surprise over expired medications in the emergency supply. The DON added, "[Pharmacy personnel] just went through it." During interview on 2/3/15, at 5:19 p.m. a pharmacist from the facility's supplying pharmacy indicated the usual practice was to review expiration dates of all medications in the emergency supply box whenever a medication was replaced after facility use. The facility's Emergency Drug Box policy revised 1/15, identified the pharmacy which owned the emergency medication supply, was responsible for removing any drug that was outdated. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and the consulting pharmacist could develop a system to ensure the emergency medication supply were not expired. The DON could delegate nursing staff to monitor the emergency medication supply. The quality assessment and assurance (QA&A) committee could randomly audit the emergency medication supply for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		
21735	MN Rule 4658.1420 Solid Waste Disposal Solid wastes, including garbage, rubbish, recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not	21735		

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21735	Continued From page 19	21735		

create a nuisance or fire hazard, nor provide a breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure outside storage receptacles were maintained in a manner which contained the refuse, thereby preventing overflow and keeping the grounds free from litter and trash. This had the potential to affect all 59 residents who resided in the facility.

Findings include:

During observation on 2/2/15, at 7:10 a.m. the facility's dumpster area included three- large, blue dumpsters, located to the West-side of the nursing home, near the curb and street. The attached dumpster covers to the first and second dumpster units (closest to the street) were pushed up, approximately three to four feet, by white/clear garbage bags heaping from the receptacles. Both dumpster units were overfilled with trash bags. One white/clear bag full of trash was observed on the street, with vehicles parked in front of it.

On 2/2/15, at 8:16 a.m. Maintenance (M)-A and M-B provided a tour of the facility's dumpster area. M-A stated the dumpsters were emptied at Noon, on Mondays and Thursdays by a sanitation company. M-A was noted to pick up the trash bag that was lying in the street and placed it into one of the overfilled dumpsters. M-B stated the dumpsters became full after the weekend and

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21735	Continued From page 20 they could not control the volume of trash, or the trash that lay on the ground, as the sanitation company spilled bags when they emptied the units. M-B added, people who lived in town added their trash to the facility's dumpsters, which were also to be used for an assisted living facility and other housing units that were owned by the same company. M-B reported some campground garbage was emptied there as well. The facility's undated Garbage Procedure, failed to address garbage overflow and procedures to keep the grounds free of litter or trash. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review, revise procedures related to the use and maintenance of the outside garbage receptacles. The administrator or designee could provide staff education and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21735		