CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: E3HQ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COMI	HE STAT	E SURVEY	AGENCY	Facility ID: 00474			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245402 2.STATE VENDOR OR MEDICAID NO. (L2) 938342500		3. NAME AND ADE (L3) GLENWOOD (L4) 719 SOUTHE (L5) GLENWOOD	VILLAGE CAI AST 2ND STRE	RE CENTE		(L6) 56334	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9)		7. PROVIDER/SUP	05 HHA	09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint	
6. DATE OF SURVEY 04/24/2015 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI	CE	FISCAL YEAR ENDING	G DATE: (L35)	
•	64 (L18)	B. Not in Comp	ce With quirements		2. 3. 4.	Approved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code	6. Scope of Serv 6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room	tor	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 64 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILIT	TY MEETS (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARKS (IF A See Attached Remarks	PPLICABLE S	SHOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE Miriam Thornquist, HFF	NEII	Date : 0	04/30/2015	(L19)	18. STATE SURVEY AGENCY APPROVAL Date: Mat. Westh, Enforcement Specialist 05/05/2015 (L20				
PA	RT II - TO	BE COMPLETEI) BY HCFA RI	EGIONAI	OFFICE (OR SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L21)		PLIANCE WITH C TS ACT:	IVIL	21.		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCF.	A-1513)	
22. ORIGINAL DATE 23. I OF PARTICIPATION 12/01/1986 (L24)	TC AGREEMI BEGINNING (L41)		4. LTC AGREEME ENDING DATI (L25)		VOLUNTA 01-Merger,		INVOLUN' 05-Fail to M	L30) FARY feet Health/Safety feet Agreement	
	ALTERNATIVI A. Suspension of the suspension of t		(L44) (L45)			nvoluntary Termination eason for Withdrawal	OTHER 07-Provider 00-Active	Status Change	
28. TERMINATION DATE: (I	29	. INTERMEDIARY/CA	ARRIER NO.	(L31)	30. REMAI	RKS			
31. RO RECEIPT OF CMS-1539 (L	32	. DETERMINATION O 03/24/2015	F APPROVAL DAT	(L33)		ted 05/13/2015 (

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00474

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

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.



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.

Glenwood Village Care Center April 28, 2015 Page 2

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

Sincerely,

mark Weath

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



RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On April 24, 2015,
I, MARY S. KRUEGER, Administrator, received (Name)(Please Print) (Title)(Please Print) 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: Name)(Please Print), Wilministrator, Date 4/24/15 (Name)(Please Print) (Title)(Please Print)
DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE
On April 24, 2015, I, Miriam Thornguist, R.N. IFE II, of the Division of (Name)(Please Print) (Title)(Please Print) 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 Kruoger, Adminstrator (Name)(Please Print) (Title)(Please Print) Signed: Municipal Humpunst, R.N. HELL, Date 4/24/15 (Name)(Please Print) (Title)(Please Print)



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 Weath

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



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.

Glenwood Village Care Center April 30, 2015 Page 2

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 Weath

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245402	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y4)	Item		(Y5)	Date	(Y4)	Item	-	(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0441		04/07/2015	1	D Prefix					ID Prefix			
Reg. #	483.65		-		Reg. #					Reg. #			
LSC					LSC				<u> </u>	LSC			
			Correction					Correction					Correction
ID Prefix			Completed	1	D Prefix			Completed		ID Prefix			Completed
Reg. #			-		Reg. #			-		D#			
-			-		LSC					-			_
			•	 					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-	1	D Prefix			-		ID Prefix			
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LSC					LSC				<u> </u>	LSC			
			Correction					Correction					Correction
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Reg. #										Reg. #			
LSC				ļ						LSC			
Reviewed By		Reviewed I	Ву	Date	:	Signature of	Surve	yor:				Date:	
State Agency	,	PK/mr	n	04	/30/2015		31.	593				04/24	4/2015
Reviewed By		Reviewed I	Ву	Date	:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of										
2/4/2015					Unco	rrecte	d Deficiencies	(CMS	-2567) Sent to	o the Facility?	YES	NO	

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00474	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/24/2015
Name	e of Facility		Street Address, City, State, Zip Code	1
GLENWOOD VILLAGE CARE CENTER			719 SOUTHEAST 2ND STREET	

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).

(4) Item	(YS	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
		Correction			Correction				Correction
ID E "		Completed	ID 5 . 7		Completed				Completed
ID Prefix	21375	04/07/2015	ID Prefix		=		·		
	MN Rule 4658.0800 Subp	<u>. 1</u>	Reg. #			Reg. #	<u> </u>		
LSC		_	LSC			LSC	;		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix	·		
Reg. #			Reg. #			Reg. #	<u> </u>		
LSC		_	LSC			LSC	<u> </u>		
		Correction			Correction				Correction
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ID Prefix		_	ID Prefix		-	ID Prefix	·		_
Reg. #			Reg. #			Reg. #	ŧ		
LSC		_	LSC			LSC	:		
		Correction			Correction				Correction
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Reg. #			Reg. #			Reg. #	‡		
LSC		_	LSC			LSC	;		
		Correction			Correction				Correction
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Reg.#			Reg. #			Reg. #			
LSC		_	LSC			LSC	<u> </u>		
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:	•		Date:	
State Agency	PK/m	m	04/28/2015	31	593			04/	24/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to	Survey Completed on: 2/4/2015					Deficiencies. Was es (CMS-2567) Sen		YES	NO
		(5/99)		Page 1 of 1		·	Event ID:	E3HQ13	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: E3HQ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGE	NCY	F	acility ID: 00474
MEDICARE/MEDICAID PROVIDER NO. (L1) 245402 2.STATE VENDOR OR MEDICAID NO. (L2) 938342500		3. NAME AND ADI (L3) GLENWOOI (L4) 719 SOUTHE (L5) GLENWOOI	O VILLAGE CAI EAST 2ND STRE	RE CENTI	ER (L6) 56	6334	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8)2. Recertification4. CHOW6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERS (L9)	HIP	7. PROVIDER/SUP	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 03/19/201 : 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	64 (L18) 64 (L17)	X B. Not in Comp	ce With quirements	n	2. Technic 3. 24 Hou	cal Personnel ir RN RN (Rural SNF) ifety Code	Following Requirements: 6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12)	tor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 64 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEE		(L15)	
16. STATE SURVEY AGENCY REMARKS (IF See Attached Remarks 17. SURVEYOR SIGNATURE	APPLICABLE S	HOW LTC CANCELL Date:	ATION DATE):		18. STATE SURVE	Y AGENCY APP	PROVAL	Date:
Patricia Bernstetter, HFI	ENEII		04/14/2015	(L19)	Mark M	reath, E	Enforcement Specia	04/29/2015 (L20)
P	ART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	L OFFICE OR SI	NGLE STATI	E AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participat 2. Facility is not Eligible	e (L21)		IPLIANCE WITH C ITS ACT:	CIVIL	2. Ow		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
OF PARTICIPATION 12/01/1986 (L24)	LTC AGREEMI BEGINNING (L41)	DATE	4. LTC AGREEME ENDING DATE (L25)		26. TERMINATIO VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W 03-Risk of Involunta		INVOLUNT 05-Fail to Mot tt 06-Fail to Mot	L30) 'ARY eet Health/Safety eet Agreement
(L27)	A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		04-Other Reason for	Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C.	ARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION C 03/24/2015	DF APPROVAL DA	(L33)	Posted 05/0'		VAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00474

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 facility of the following:

 ξ 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.



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



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.

Glenwood Village Care Center April 24, 2015 Page 2

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.

Glenwood Village Care Center April 24, 2015 Page 3

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

PRINTED: 03/27/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	* *-			7	OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	;	(X3) DATE COMP	SURVEY LETED
		245402	B. WING		APR 1 3 2015			₹ 19/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP C	ODE		
GLENWO	OD VILLAGE CARE CEN	TER		1	19 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	₫ Q++		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0)00}				
{F 441} SS=F	of this department on compliance with feder during a recertification During this visit the fo determined to be not	ral deficiencies issued n survey exited on 2/4/15. Ilowing regulations were	{F 4	l 4 1}				
	safe, sanitary and cor	gram designed to provide a infortable environment and evelopment and transmission						
	Program under which (1) Investigates, contrin the facility; (2) Decides what progshould be applied to a	blish an Infection Control it - rols, and prevents infections redures, such as isolation, an individual resident; and if of incidents and corrective						
	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact will direct contact will trant (3) The facility must re-	n Control Program Ident needs isolation to Infection, the facility must rohibit employees with a le or infected skin lesions th residents or their food, if smit the disease. equire staff to wash their ct resident contact for which					APP 41	36

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

TITLE

(X6) DATE

FORM APPROVED

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.

4-8-2015

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

PRINTED: 03/27/2015 FORM APPROVED

OLIVIE	CT ON WILDIOMNE &	MEDICAID SERVICES			(OMB NC). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE	
		245402	B. WING _				R
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE I	03/	19/2015
				719 SOUTHEAST 2ND STREET	DL		
GLENWO	OD VILLAGE CARE CEN	TER		GLENWOOD, MN 56334			
(X4) ID	SHMMADVST	ATEMENT OF DEFICIENCIES				***************************************	T
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{F 441}	Continued From negs	. 1					
(i ++ i)	. 3	9 1	{F 44	41}			
	professional practice.						
	(c) Linens						
	Personnel must handi	le store process and					
		to prevent the spread of					
	infection.	to provent the opicad of					
		is not met as evidenced					
	by:	and decourse of the Co					
		nd document review, the ish an infection control				:	
	program which include						
		nt symptoms, analysis of the					
	surveillance and inves	stigation of patterns					
	identified. This had the	e potential to affect all 58					
	residents who resided	in the facility.		F441			
	Findings include:						
	The facility's Infection			It is the policy of Glen	wood		
		o, through 3/19/15. The logs		l l			
		residents with infections for prescribed. The facility's		Village Care Center to			
	surveillance processes	s also lacked identification		all residents and empl	-		
		on of the resident within the oms that were present,		signs/symptoms of inf			
		ganism identified, and the		Infections will be track	кed		
	date the infection resc	lived. Furthermore, the logs		throughout the facility	/. All		
		investigation of patterns		nursing units will have			
	identified.	G Fallenie		_			
	During interview on 3/			infection control log th			
		-A confirmed that she does		updated daily by the c	linical		
		ntation to support tracking		managers. This inform	nation will		
		s within the facility except	also be shared at the dail				
	for charting a progress				-		į
	system (point click car interview at 3:03 n m	e). During follow up RN-A verified she was told		(Interdisciplinary team) meeting		1
		to the director of nursing		to monitor for trends.			
		was taking over infection					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/27/2015 FORM APPROVED OMB NO 0938-0391

		INEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245402	B. WING			1	R 3/ 19/2015
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	71072010
GLENWO	OD VILLAGE CARE CEN	TER		1	19 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		
(X4) ID	SI IMMADY ST	ATEMENT OF DEFICIENCIES					-
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{F 441}	given." During interview on 3/ confirmed that she do documentation to supi infections within the fa progress note in the co care). During follow up RN-B verified she was infection control and s any education in regar infections." RN-B also who was currently trace infections within the be During interview on 3/ confirmed she did not documentation to supp analysis or investigatio facility and stated, "I de and trending these infe Review of the facility p GVCC Surveillance, de facility would closely m exhibit signs/symptoms ongoing surveillance a collecting, consolidatin concerning the frequer disease or event. The identify possible cluste	o education was really (19/15, at 10:31 a.m. RN-B es not have any port tracking or trending of acility except for charting a computer system (point click o interview at 3:10 p.m. c not given any education on tated, "No I did not receive rds to tracking and trending o verified she was not sure cking and trending uilding right now. 19/14, at 1:08 p.m. DON have any further cort tracking, trending, on of infections within the control feel that I am tracking ections like I should be." roolicy titled, Infection Control ated 3/15 indicated the monitor all residents who s of infection through and has systemic method of	{F 4	141}	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 on Nursing	t d	
					Corrective Action Completed: April 7, 2015		
					,, 2022		

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245402	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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
			Correction					Correction					Correction
ID Prefix	F0282		Completed 03/06/2015		ID Prefix	E0244		Completed 03/06/2015		ID Drofiv	FOREC		Completed 03/06/2015
			03/06/2015					03/06/2015		ID Prefix			03/06/2015
Reg. # LSC	483.20(k)(3)(ii)				Reg. # LSC	483.25(c)				Reg. # LSC	483.30(e)		_
				-					-				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0371		03/06/2015		ID Prefix	F0372		02/09/2015		ID Prefix	F0431		02/06/2015
•	483.35(i)					483.35(i)(3)					483.60(b), (d), (e		_
LSC					LSC					LSC			
			Correction					Correction					Correction
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Reg. #					Reg.#			-		Reg. #			_
LSC					LSC								_
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			Correction					Correction					Correction
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			Correction					Correction					Correction
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ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Revi	ewed E	Ву	Da	te:	Signature o	f Surve	yor:	•			Date:	
State Agency	y PK	₹/mn	n	03	/27/20	15		3350	53			03/1	9/2015
Reviewed By	Revi	ewed E	Ву	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed o	n:		Check for any Uncorrected Deficiencies. Was a Summary of					a Summary of	l			
2/4/2015			Uncorrected Deficiencies (CMS-2567) Sent to the Facility?						YES	NO			

PRINTED: 03/27/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00474	B. WING		R 03/19/2015	
NAME OF PR	ROVIDER OR SUPPLIER		LRESS, CITY, STA	TE, ZIP CODE	03/13/2013	
GLENWO	OD VILLAGE CARE CEN	TER	IEAST 2ND ST	REET		
022		GLENWOO	D, MN 56334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{2 000}	Initial Comments		{2 000}			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of find the Minnesota Depart Determination of whe corrected requires contains the Minnesota Depart Determination of whe corrected requires contains to a survey of the corrected requires contains to a survey.	ther a violation has been mpliance 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.					
	the following correction corrected. This uncorrected and will be reviewed.			Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nurs Homes.		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		.52	A. BUILDING:			
		00474	B. WING		R 03/19/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GLENWO	OD VILLAGE CARE CEN	TER	IEAST 2ND ST	REET		
		GLENWOO	D, MN 56334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{2 000}	Continued From page	: 1	{2 000}			
				The assigned tag number appears in a far left column entitled "ID Prefix Tag. The state statute/rule number and the corresponding text of the state statute 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 whare in violation of the state statute after statement, "This Rule is not met as evidenced by." Following the surveyof findings is the Time Period For Correct PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	ich er the ors tion. G OF	
{21375}	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	{21375}			
	home must establish	control program. A nursing and maintain an infection gned to provide a safe and				
	by: Uncorrected based or	t is not met as evidenced the following findings. The er issued on 2/19/15, will				

Minnesota Department of Health

STATE FORM 6899 E3HQ12 If continuation sheet 2 of 4

PRINTED: 03/27/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
						R	
		00474	B. WING			19/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
		719 SOU	THEAST 2ND ST	REET			
GLENWO	OD VILLAGE CARE CEN	TER	OOD, MN 56334				
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
				DEI ICIENCI)		-	
{21375}	Continued From page	2	{21375}				
	remain in effect. Pena	alty Assessment Issued.					
		nd document review, the					
		lish an infection control					
	program which includ						
		nt symptoms, analysis of the					
	surveillance and inves	stigation of patterns					
	identified. This had th	e potential to affect all 58					
	residents who resided	d in the facility.					
	Findings include:						
	The facility's Infection	_					
		5, through 3/19/15. The logs					
	_	residents with infections for					
		e prescribed. The facility's					
	T = 1	es also lacked identification					
	_	ion of the resident within the toms that were present,					
		rganism identified, and the					
		olved. Furthermore, the logs					
		or investigation of patterns					
	identified.						
	During interview on 3	/19/15, at 10:20 a.m.					
)-A confirmed that she does					
	not have any docume	entation to support tracking					
	or trending of infection	ns within the facility except					
		s note in the computer					
	system (point click ca						
		RN-A verified she was told					
		to the director of nursing					
	, , , ,	was taking over infection					
		lo education was really					
	given."	/19/15, at 10:31 a.m. RN-B					
	confirmed that she do						
		port tracking or trending of					
		acility except for charting a					
		computer system (point click					
	ı · •	p interview at 3:10 p.m.					
		s not given any education on					
		stated, "No I did not receive					
		ards to tracking and trending					

Minnesota Department of Health

STATE FORM 6899 E3HQ12 If continuation sheet 3 of 4

PRINTED: 03/27/2015 FORM APPROVED

Minnesot	a Department of Health	າ			_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI			
		00474	B. WING		F 02/4			
		00474			03/1	9/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE				
GI ENWO	OD VILLAGE CARE CEN	719 SOUT	THEAST 2ND ST	REET				
OLLIVIO	OD VILLAGE GARE GEN	GLENWO	OD, MN 56334					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
{21375}	Continued From page	e 3	{21375}					
	infections." RN-B als who was currently trainfections within the b During interview on 3 confirmed she did not documentation to supanalysis or investigatifacility and stated, "I cand trending these in Review of the facility GVCC Surveillance, of facility would closely exhibit signs/sympton ongoing surveillance collecting, consolidatic concerning the frequed disease or event. The identify possible clust organisms, or increase a timely manner. SUGGESTED METH The director of nursin review and revise pol to components of the and develop a monitor compliance.	o verified she was not sure cking and trending building right now. /19/14, at 1:08 p.m. DON						

Minnesota Department of Health

STATE FORM 6899 E3HQ12 If continuation sheet 4 of 4

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00474	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/19/2015
Name of Facility		1	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	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
ID Prefix	20565	Completed 03/06/2015	ID Prefix	20905	Completed 03/06/2015		ID Prefix	21200		Completed 03/06/2015
	MN Rule 4658.0405 Subp.	=		MN Rule 4658.0525 Subp.	=			MN Rule 4658.0	168U 611P	
LSC	Mil Kule 4030.0403 Subp.		LSC	wild Rule 4030.0323 Subp.	-		LSC		7660 Sub	
		Correction			Correction					Correction
ID Prefix	21426	Completed 03/19/2015	ID Prefix	21600	Completed 02/06/2015		ID Prefix	21735		Completed 02/09/2015
	MN St. Statute 144A.04 Su	-		MN Rule 4658.1335 Subp.	_			MN Rule 4658.	1420	
LSC	Time of otal die 1444.04 ou		1.00	MIN IXUIC 4000.1000 GUDD.	<u>-</u> -		LSC		1420	
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #		-	Reg. #		_		Reg. #			
		-	LSC		-					
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				Reg. #			
			LSC		-		-			_
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #		-	Reg. #		_		Reg. #	-		
LSC			LSC				LSC			
Reviewed By	Reviewed I	Зу	Date:	Signature of Surve	eyor:				Date:	
State Agency	PK/mi	m	04/24/20	15	335	63			03/	19/2015
Reviewed By	Reviewed I	Зу	Date:	Signature of Surve	eyor:				Date:	
Followup to	Survey Completed on: 2/4/2015							a Summary of to the Facility?	YES	NO
STATE FORM		5/99)	1	Page 1 of 1				Event ID:	F3HQ12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		ID: E3 Facility	BHQ y ID: 00474
MEDICARE/MEDICAID PROVIDE (L1) 245402 2.STATE VENDOR OR MEDICAID N (L2) 938342500		3. NAME AND ADDRESS OF FACILITY (L3) GLENWOOD VILLAGE CARE CE (L4) 719 SOUTHEAST 2ND STREET (L5) GLENWOOD, MN			NTER (L6) 56334	1. Initia 3. Termi 5. Valid	l 2. ination 4. ation 6.	N: 2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)6. DATE OF SURVEY 02/04	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRI 02 SNF/NF/Dual 06 PRTF 10 NF		09 ESRD	02 (L7) 13 PTIP 22 CLIA 14 CORF		7. On-Site Visit 9. Other 8. Full Survey After Complaint		
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2015 (L34) (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC			EAR ENDING DA	TE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	64 (L18)	Compliance1. Ac X B. Not in Com	nce With equirements e Based On: ecceptable POC	ram	And/Or Approved Waivers 2. Technical Personr 3. 24 Hour RN 4. 7-Day RN (Rural 5. Life Safety Code * Code: B*		Requirements: Scope of Services I Medical Director Patient Room Size Beds/Room	Limit
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF 64	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	((L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENO	CY APPROVAL	D	Pate:
Denise Erickson, HI	E NEII	0	3/06/2015	(L19)	Mark Meath	、, Enforceme	nt Specialist	03/19/2015 (L20)
PA	RT II - TO BE	COMPLETED E	BY HCFA RE	, ,	L OFFICE OR SINGLE	STATE AGE	ENCY	(E20)
DETERMINATION OF ELIGIBII	Participate		PLIANCE WITH ITS ACT:	I CIVIL	21. 1. Statement of Fi2. Ownership/Cor3. Both of the Abo	ntrol Interest Discl	(HCFA-2572) osure Stmt (HCFA	-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	LTC AGREEM	IENT	26. TERMINATION ACTIO	ON:	(L30)	
OF PARTICIPATION 12/01/1986	BEGINNING	DATE	ENDING DAT	TE .	<u>VOLUNTARY</u> 01-Merger, Closure	00_	INVOLUNTARY 05-Fail to Meet H	=
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbu		06-Fail to Meet A	greement
25. LTC EXTENSION DATE:	VE SANCTIONS a of Admissions:			03-Risk of Involuntary Termina 04-Other Reason for Withdraw	al	OTHER 07-Provider Statu 00-Active	as Change	
(L27)	B. Rescind Su	spension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
	(L28)	03001		(L31)	Posted 03/24/201	15 Co.		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				

(L33)

DETERMINATION APPROVAL

(L32)



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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

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

PRINTED: 02/19/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION V (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ MAK 0972015 245402 B. WING 02/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET **GLENWOOD VILLAGE CARE CENTER** GLENWOOD, MN 56334 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 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 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 F282 PERSONS/PER CARE PLAN SS=D It is the policy of the facility to The services provided or arranged by the facility have services provided by must be provided by qualified persons in accordance with each resident's written plan of qualified persons trained to care. follow the resident's written plan of care. This REQUIREMENT is not met as evidenced by: R19 routinely refuses Based on observation, interview and document repositioning when in his review, the facility failed to provide repositioning wheelchair. A referral has been assistance as directed by the care plan for 1 of 2 residents (R19) in the sample reviewed for made to OT to assess positioning. wheelchair positioning. Nursing Assistants have been Findings include: retrained about the need to follow the plan of care and R19's quarterly Minimum Data Set dated offer repositioning as outlined. 12/30/2104, indicated R19 was at risk for pressure related ulcers. Resident refusal must be documented.

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

TITLE

CED

(X6) DATE

ony deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/19/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245402 B. WING 02/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET **GLENWOOD VILLAGE CARE CENTER** GLENWOOD, MN 56334 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282 Continued From page 1 F 282 Random Audits will be R19's care plan last revised 1/29/2015, indicated R19 had an alteration in skin integrity, required conducted on repositioning x4 staff assistance to reposition and directed staff to weeks. Audits will be shared at reposition R19 every two hours. The care plan Quality Assurance for review also indicated R19 had a history of refusing repositioning and directed staff to encourage R19 and compliance. to reposition. Responsible Person: Director of On 2/3/15, from 11:48 a.m. until 3:03 p.m. R19 Nursing. was continuously observed seated in the wheelchair (3 hours and 45 minutes) without **Corrective Action Completed** repositioning. by: 3/6/15 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.

directed.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245402	B. WING	i	02	/04/201E	
	PROVIDER OR SUPPLIER OOD VILLAGE CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334		2/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(OULD BE	(X5) COMPLETION DATE	
SS=D	On 02/04/2015, at 4 would expect staff thours as directed. Review of the facilith Plans indicated the Plans was to provid comprehensive assistrengths, problems be met and evaluate 483.25(c) TREATMI PREVENT/HEAL Problems to the facility who enters the facility and pressure sores receservices to promote prevent new sores for this REQUIREMEN by: Based on observation to prositioning assistant development of pres	y policy titled Resident Care purpose of Resident Care e continual care, essment of resident's, needs and how they are to ed. ENT/SVCS TO RESSURE SORES The hensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the ondition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and	F 2		ss ion e lent res		

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

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	JLTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245402	B. WING	G	0.0	\\0.4\\0.4\=	
	PROVIDER OR SUPPLIER OOD VILLAGE CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIF 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	, CODE	<u>2/04/2015 </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	R19's current Physilast updated 1/29/2 diagnosed with dem weakness, urinary in dermatitis, generalized dermatitis, eczema male genital organs. R19's admission Mi 10/9/2014, and qual both indicated R19 limpairment, utilized frequently incontined pressure ulcers and assistance with all a except for eating. R19's care plan last R19 had an alteration advanced age, decrediabetes and inconsiplan indicated R19 umattress, pressure mand directed staff to hours. The care plan of refusing reposition encourage R19 to result of the refusing Kardex Sheet) for R19, dated was to be repositioned.	icians Order Summary Report 015, indicated R19 was nentia, diabetes, depression, incontinence, constant zed muscle weakness, contact and inflammatory disorder incommum Data Set (MDS) dated and inflammatory disorder incommum Data Set (MDS) dated aterly MDS dated 12/30/2104, and severe cognitive a urinary catheter, was not of bowel, was at risk for required extensive staff ctivities of daily living (ADLs), are vised 1/29/2015, indicated in skin integrity related to eased mobility, incontinence, istent repositioning. The care atilized a pressure reducing educing wheelchair cushion reposition R19 every two indentified R19 had a history hing, and directed staff to position. (Nursing Assistant Care da 1/5/2015, indicated R19 ed every 2 hours.	F	A comprehensive skin assessment has been completed for R19 and plan updated. R19 conrefuse to be reposition sitting in his wheelchai allowing staff to assist bathroom and bed. Policy was reviewed wistaff in regard to comprehensive skin assessments. Nursing Assistants have retrained about the nefollow the plan of care offer repositioning as of Audits will be conducted new admissions x 4 we comprehensive skin assessments. Audits wiconducted on new ope for comprehensive skin	I care intinues to ned when ir, him to ith RN e been ed to and outlined. ed on all neks for ill be in areas		
		rs included: dimethicone his every day and evening					

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

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		ONSTRUCTION	(X3) E	OATE SURVEY OMPLETED
		245402	B. WING				00/04/004-
	(EACH DEFICIENC	CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	719 S GLEI	ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST 2ND STREET NWOOD, MN 56334 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION UID BE	02/04/2015 (X5) COMPLETION DATE
	buttocks and scrotule very day and every keep off bottom as 12/14/14, lamisilated as needed since 10 scrotum three times ceftin for penis ulce 2/2/15. Review of R19's nur 10/7/2014, to 2/3/20 -On 12/19/14, indicated was completed plan remained approximately on 1/17/2015, indicated approximately on 1/18/2015, indicated number of 1/30/2015, indicated number of 1/30/2015, indicated A & D Ointibuttocks and an openoted on the left button on 2/3/15, from 11:4 was continuously obswheelchair (3 hours are positioning.	A&D ointment to groin, am to prevent skin breakdown hing shift since 1/23/15, to much as possible since cream to groin, twice per day 1/2/14, ketoconazole gel to a per day since 1/6/15, and r infection for 10 days since rsing progress notes from 1,5 revealed the following: ated R19's monthly care planed and indicated R19's care opriate. The state of R19 did not want to lay soure / assist in healing his even after encouragement. The ated R19 was provided with treatments. The note also ment was applied to the narea with bleeding was ock cheek. 8 a.m. until 3:03 p.m. R19	F3	14	assessments x4 weeks. Au will be shared at Quality Assurance for review and compliance. Responsible Person: Direct Nursing. Corrective Action Completed by: 3/6/15	or of	

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

STATEM AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		245402	B. WING			02/04/2015	
	OF PROVIDER OR SUPPLIER WOOD VILLAGE CARE	CENTER	•	STREET ADDRESS, CITY, STATE, 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	ZIP CODE	02/04/2015	
(X4) II PREFI TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(= 12.1.20111270	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 31	(NA)-A stated she was from 6:30 a.m. to 3 not sure what repositioned every; R19 had not been or 7 hours and 36 min R19 had not been or repositioning assistated. On 2/04/2015, at 9:0 worked with R19 on supposed to repositioning assistated to repositioning assistated to repositioning assistated. NA-C also statissues for the last 6 R19 was not assisted wheelchair during the hours and 36 minuted. On 02/04/2015, at 2:0 (RN)-B confirmed R-conditions and risk that care plan and stated every two hours as dwas not aware of R1 if so, staff were supposed to reposition the computation of the reposition of the reposit of the reposition of the reposition of the reposition of the re	was assigned to care for R19:00 p.m. NA-A stated she was sitioning directive was on was sure R19 was to be 2 hours at night. NA-A stated epositioned since 7:18 a.m. (utes) this morning and verified offered nor refused ance. O1 a.m. NA-C who also 2/3/15, stated staff were ion R19 every 2-3 hours and im off his bottom more than ted R19 has had different skin months. NA-C also confirmed d / repositioned out of his e day shift on 2/3/15, for 7 es. 12 p.m. registered nurse 19's long standing skin here of and verified R19's R19 was to be repositioned irected. RN-B stated she 9 refusing repositioning and osed to document the uter. 11 p.m. RN-B stated she reposition R19 every 2 didocument if refused.	F3	314			
	Repositioning (Tissue	policy titled Turning and Tolerance) Observation					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CAL BROWNER OF DECICIONAL PROPERTY OF DECICIONAL PROPERT

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DA CO	TE SURVEY MPLETED
		245402	B. WING		03	2/04/2015
	PROVIDER OR SUPPLIER OOD VILLAGE CARE			STREET ADDRESS, CITY, STATE, ZIP COD 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	E	./04/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BF	(X5) COMPLETION DATE
	Policy and Proceduran individualized turned every 2 hour individual needs an teach staff to make alter pressure point use different chairs non-compliant with reflected on their cat 483.30(e) POSTED INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number a by the following cate unlicensed nursing a resident care per shandle and the control of the current date. The facility must post a specified nurse of the control of the current date. The facility must post a control of the current date. The facility must post post practive cational nurses (and the control of the current date. The facility must post post practive cational nurse of the facility must post precified above on a control of the current date. The facility must post precified above on a control of the current date of the current date. The facility must post precified above on a control of the current date. The facility must post precified above on a control of the current date.	re, dated 3/04, indicated once rning an repositioning mined the resident would be sor more often according to do assist resident and to small changes in position to severy 30 minutes while up, alternately and if resident was repositioning it would be re plan. NURSE STAFFING and the actual hours worked agories of licensed and staff directly responsible for lift: ses. cal nurses or licensed and sedined under State law). aides. t the nurse staffing data and adaily basis at the beginning nust be posted as follows: format. te readily accessible to	F 35	F356: It is the policy of Glenw Village Care Center to actual daily staffing hours of at the beginning of each so The following information be posted facility name, cur date, and total number actual hours worked by following categories licensed and unlicensed so directly responsible for residuare per shift: register nurses; licensed praction nurses; certified nurse aim	post daily shift. will rent of the of staff dent ered tical ides The be The	

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DAT	TE SURVEY MPLETED
		245402	B. WING		000	/04/0045
GLENW	PROVIDER OR SUPPLIER OOD VILLAGE CARE SUMMARY STA	TEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334 PROVIDER'S PLAN OF CORRECTION		/04/2015
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRECTIVE ACTION SHOUL)	D RE	(X5) COMPLETION DATE
	The facility must may staffing data for a may required by State law. This REQUIREMENT by: Based on observation review, the facility far hours posting was undours worked. This is 59 residents who resolved with the facility review, the initial tour nursing hours posting sleeve, secured to a reception desk in the posting included the facility name, date, how for registered practical nurses (LPN (NAs). However, the land was not updated on 2/1/15. During subsequent of the facility name, date, how work for registered practical nurses (LPN (NAs). However, the land was not updated on 2/1/15. During subsequent of the following posting, the follow 2/1/15, at 4:10 p.r. was dated 1/30/15, ar effect the hours work on 2/2/15, at 7:00 a.m.	aintain the posted daily nurse inimum of 18 months, or as w, whichever is greater. IT is not met as evidenced on, interview and document illed to ensure the nursing pdated daily to reflect current had the potential to affect all sided in the facility and family it to view this information. If on 2/1/15, at 9:22 a.m. the g was observed in a plastic wall, directly across from the facility's main lobby. The current resident census, ours of labor and each shift in nurses (RNs), licensed in licensed in license (RNs), licensed in our posting was dated 1/30/15, to reflect the hours worked in the nursing owing was identified: In nursing hours posting ind was not updated to	F3	Daily nursing staffing posting policy was reviewed and remains appropriate. Weeke 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 week 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	end e o	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245402	B. WING		02/04/201	E
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	1 02/04/201	<u>ə</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CROSS-REFERENCED CROSS-REFERENCED TO THE APPROPRIED CROSS-REFERENCED TO THE APPROPRIED CROSS-REFERENCED C	D BE COMPLE	TION
F 371 SS=F	was not updated to 2/2/15. On 2/3/15, at 9:29 a was dated 1/30/15, reflect the hours wo During interview on director of nursing (I receptionist was res nursing hours posting charge nurse was reposting on weekend posting should have DON added, "I would nurse) to keep the p The facility's Posting policy dated 12/10, in post the number of n for providing direct cishift, on a daily basis 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, diunder sanitary condit	reflect the hours worked on a.m. nursing hours posting and was not updated to rked on 2/3/15. 2/4/15, at 9:27 a.m. the DON) confirmed the facility's ponsible for updating the ag on weekdays and the esponsible for updating the s. The DON verified the staff been updated daily. The dexpect her (the charge osting up to date." Daily Nursing Staff Schedule adicated the facility was to pursing personnel responsible are to residents, for each are to residents, for each or sources approved or ory by Federal, State or local stribute and serve food ions	F 37			
	I NIS REQUIREMENT	is not met as evidenced				

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245402	B. WING		02	/04/201E
	PROVIDER OR SUPPLIER DOD VILLAGE CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	;ODE	/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	review, the facility far preparation equipm between each use, This had the potenti who ate in the facility who ate in the facility. Findings include: During the initial kitca.m. dishes and uted drying mat, atop the attached to the two-(C)-A stated that she the entrees, vegetable foods, cold salads a meals. C-A stated the bowls, spatulas, whis preparation equipmed once per day, in the stated she washed the soap, rinsed them of them to air dry on the these items were the to be used by other odd not know how the monitored for rinsing in the two-compartment of the water, and confirmed measuring the rinse of the possible properties of the water, and confirmed measuring the rinse of the possible properties of the water, and confirmed measuring observation of at 9:35 a.m. a spatulation.	ion, interview and document ailed to ensure food ent was properly sanitized to prevent food borne illness. ial to affect 59 of 59 residents by. Then tour on 2/1/15, at 9:15 nsils were observed on a stainless steel counter, compartment sink. Cook exprepared and cooked all of oles, ground foods, puree and desserts for resident at she washed pots, pans, sks and any other food ent that they used more than two-compartment sink. C-A he equipment with Dawn dish if with hot water and allowed en either re-used or put away, dietary staff. C-A stated she water temperature was the equipment she washed ent sink. C-A stated she had temperature of the rinse if there was no record for	F 37	The dietary manager has educated all cooks about sanitizing all dishes and uproper sanitation. On 3/ an additional memo of education was attached to dietary employee's paych to ensure they received to information on proper sanitation. Random observations will made x4 weeks and report the Quality Assurance Committee. Person Responsible: Dieta Manager Corrective Action Complete by: 3/6/15	t utensils re '5/15 to all necks the I be rted to	

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245402	B. WING	i	02	/04/201E
	PROVIDER OR SUPPLIER DOD VILLAGE CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	CODE	/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 371	sink. On 2/4/15, at 8:26 a reported it was her ecooks sent all dished dish machine, after manager confirmed food preparation ute only washing them wrinsing them under hit two-compartment sing through the dish mastated that she educing re-use equipment ar	using the two-compartment .m. the dietary manager expectation that the facility s and utensils through the each use. The dietary C-A and C-B were re-using ensils and equipment, after with Dawn dish soap and	F3	171		
F 372 SS=F	identified all small-way pots/ pans were to busing the commercial minimum, final hot widegrees Fahrenheit (483.35(i)(3) DISPOS PROPERLY The facility must disperoperly. This REQUIREMENT by: Based on observation review, the facility fail receptacles were main contained the refuse,	achine Policy dated 5/13, ares, silverware and any e cleaned and sanitized al dish machine, with a rater rinse temperature of 180 (F), for proper sanitization. E GARBAGE & REFUSE cose of garbage and refuse on, interview and document led to ensure outside storage intained in a manner which thereby preventing overflow and free from litter and	F 37	F372 It is the policy of the fadispose of garbage and properly.	acility to d refuse	

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			71	REET ADDRESS, CITY, STATE, ZIP CODE 9 SOUTHEAST 2ND STREET LENWOOD, MN 56334	1 02	2/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) RE	(X5) COMPLETION DATE
	trash. This had the residents who residents white/s dumpster and tached dumpster units (clospushed up, approximally white/s area garbage receptacles. Both dumpster units (clospushed up, approximally with trash bags. One was observed on the infront of it. On 2/2/15, at 8:16 a. M-B provided a tour area. M-A stated the Noon, on Mondays a company. M-A was not that was lying in the softhe overfilled dump dumpsters became for they could not controtrash that lay on the goompany spilled bags units. M-B added, peadded their trash to the were also to be used and other housing unsame company. M-B garbage was emptied	potential to affect all 59 ed in the facility. on 2/2/15, at 7:10 a.m. the rea included three-large, blue to the West-side of the the curb and street. The covers to the first and second est to the street) were nately three to four feet, by bags heaping from the impster units were overfilled white/clear bag full of trash estreet, with vehicles parked of the facility's dumpster dumpsters were emptied at nd Thursdays by a sanitation oted to pick up the trash bag street and placed it into one osters. M-B stated the ull after the weekend and I the volume of trash, or the ground, as the sanitation is when they emptied the cople who lived in town the facility's dumpsters, which for an assisted living facility its that were owned by the reported some campground	F3	772	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 or Plant Operations. Corrective Action Completed: 2/9/15	f	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245402	B. WING		00	104/0045	
GLENW	PROVIDER OR SUPPLIER OOD VILLAGE CARE			STREET ADDRESS, CITY, STATE, ZIP CO 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	DDE	/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
- - - - - - - - - - - - - - - - - - -	to address garbage keep the grounds from 483.60(b), (d), (e) DO LABEL/STORE DRUTHE facility must ema a licensed pharmaci of records of receipt controlled drugs in succurate reconciliation records are in order controlled drugs is more controlled drugs is more controlled drugs is more controlled drugs is more conciled. Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with Spacific must store all locked compartments controls, and permit controls, and permit controls access to the keep controlled drugs listed drugs	overflow and procedures to see of litter or trash. RUG RECORDS, JGS & BIOLOGICALS ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically s used in the facility must be se with currently accepted es, and include the ry and cautionary expiration date when tate and Federal laws, the drugs and biologicals in so under proper temperature only authorized personnel to	F 43	F431	ensure cals e with ssional e d nd the d ctive ately. the ly. ms, ration is due ill be on		

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

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	3) DATE SURVEY COMPLETED	
		245402	B. WING	j	00	0/04/0045	
	PROVIDER OR SUPPLIER OOD VILLAGE CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	1	2/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
1 1 1 1	by: Based on observation review, the facility farewiew, the facility farewiew, the facility faremergency supply in removing expired management of 1 administered antibion expired and had the residents who were medications from the findings include: On 2/3/15, at 1:11 p. medication cart was nurse (RN)-A. One of labeled Cipro (an antifive tablets, with three remaining in the bottle of the expired medication had expirate expired medication facility's emergency of acility's emergency of the facility's emergency of the facility's emergency of the confirmed R12 had be of one-half tablet (250 Cipro from 2/1/15, to the facility's emergency of the conducted with facility is emergency of the conducted with facility is emergency of the conducted with facility is emergency or in	on, interview and document illed to routinely evaluate nedications for expiration, edications from available use. resident (R12) who was tic medications that had potential to affect all 59 eligible to receive a facility's emergency supply. The Station-One reviewed with registered f the medication bottles was ibiotic) 500 milligrams (mg), at tablets observed as e. The label identified the ed on 1/15. RN-A identified on was obtained from the nedication supply. The Kit log was reviewed and f Cipro was signed out for expiration date), for a fact infection. RN-A een administered four doses of mg) each, of the expired 2/3/15. A thorough review of cy medication supply was RN-A, with additional expired 1, including the following: a Sulfate (a pain medication) of (injection), expired 1/1/15; (an antihistamine	F 4	The pharmacy will maintain logbook that contains the following: 1.) Date the kit was returned 2.)Date the kit was replenished 3.)initials of the technician and pharmacist was replenished 4.) the expiration date of the kit 5.) the number of the padlock seal. Person Responsible: Directo Nursing Corrective Action Completed: 2/6/15	/as s /ho on er		

PRINTED: 02/19/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245402 B. WING 02/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET **GLENWOOD VILLAGE CARE CENTER** GLENWOOD, MN 56334 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 431 Continued From page 14 F 431 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

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.

was replaced after facility use.

PRINTED: 02/19/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245402 B. WING 02/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET **GLENWOOD VILLAGE CARE CENTER** GLENWOOD, MN 56334 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 441 Continued From page 15 F 441 F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS=F SPREAD, LINENS F441 The facility must establish and maintain an It is the intent of the facility to Infection Control Program designed to provide a safe, sanitary and comfortable environment and have an infection control to help prevent the development and transmission program that provides for a of disease and infection. safe, sanitary and comfortable (a) Infection Control Program environment that prevents the The facility must establish an Infection Control development and transmission Program under which it -(1) Investigates, controls, and prevents infections of disease and infection. in the facility: (2) Decides what procedures, such as isolation, The control log will be should be applied to an individual resident; and redesigned to track all (3) Maintains a record of incidents and corrective components including location, actions related to infections. symptoms, cultures and (b) Preventing Spread of Infection organisms identified, antibiotics (1) When the Infection Control Program determines that a resident needs isolation to used and resolution. Analysis prevent the spread of infection, the facility must of infections will also be a part isolate the resident. of the surveillance. (2) The facility must prohibit employees with a communicable disease or infected skin lesions. from direct contact with residents or their food, if RN's in facility will be inserviced direct contact will transmit the disease. on the components of the (3) The facility must require staff to wash their infection control program. hands after each direct resident contact for which hand washing is indicated by accepted Person Responsible: Director of

(c) Linens

infection.

professional practice.

Personnel must handle, store, process and

transport linens so as to prevent the spread of

Nursing

3/11/15

Corrective Action Completed:

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

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245402	B. WING			02/04/2015		
	PROVIDER OR SUPPLIER DOD VILLAGE CARE	CENTER		719 S	ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST 2ND STREET NWOOD, MN 56334	1 02/	0-1/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION		
F 441	Continued From pa	ge 16	F 4	41				
	by: Based on interview facility failed to esta program which inclusurveillance of residurveillance and invidentified. This had residents who resides include:	•						
	reviewed from 6/14 identified and tracked infections for which The facility's surveil identification of the resident within the face were present, cultur identified, specific at the infection resolved lacked analysis and identified.	on Control Log(s) were through 2/15. The logs and only residents with antibiotics were prescribed. In lance processes also lacked following: location of the acility, specific symptoms that res performed/organism antibiotic used, and the date and. Furthermore, the logs for investigation of patterns						
	infection control coodid not have any fur tracking or trending facility. During a following facility. During a following facility for now." The no infection control analysis/ investigation within the facility, but been. On 2/4/15, at 2:20 p (DON) confirmed ships.	2/4/15, at 1:30 p.m. the ordinator (ICC) confirmed she ther documentation to support of infections with in the ow up interview at 1:56 p.m., nonitor antibiotic use in the e ICC verified that effectively, program of surveillance/on was being implemented at confirmed it should have .m. the director of nursing the did not have any further upport tracking, trending,						

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245402	B. WING			02/	/04/2015
	PROVIDER OR SUPPLIER OOD VILLAGE CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	, CODE	<u> </u>	0-72010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 441	facility. The DON version staff to track inference DON stated, "We are just tracking antibior A policy which direct responsibilities of the	ation of infections with in the erified it was her expectation ections within the building. The re just cleaning surfaces and	F 4	.41			

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

PRINTED: 02/19/2015 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245402	B. WING _	B. WING		02/	02/05/2015	
	ROVIDER OR SUPPLIER OD VILLAGE CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP C 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334	ODE			
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS		K	000				
	Minnesota Departmer Fire Marshal Division. Glenwood Village Carsubstantial compliance participation in Medic Subpart 483.70(a), Li 2000 edition of Nation Association (NFPA) Stode (LSC), Chapter Glenwood Village Carfour different times. Tin the 1962, is 1- storand was determined to construction. In 1975 the northeast that was (111) construction. In to the southeast that II (111) construction. In added to the west that III (111). In 2014 the 1 into a 15 bed southwer construction. The building a standard for the Information of the main flow the corridors with smoke detection in all the facility has battery in all resident sleeping monitored for automatic sprinter in the southeast that III (111) and the southeast that III (111) in 2014 the 1 into a 15 bed southwer construction. The building 13 Standard for the Information of the southeast (1999 editional all resident sleeping monitored for automatic sprinter in all resident sleeping m	standard 101, Life Safety 19 Existing Health Care. re Center was constructed at the original building was built y, with a partial basement to be of a Type II (111) an addition was added to se determined to be Type II 1978 an addition was added was determined to be Type In 1987 an addition was it was determined to be Type In 1987 an addition was renovated est wing. Type II (III) silding is divided into 6 smoke or. For system is installed and in accordance with NFPA installation of Sprinkler in). The building has a fire tomatic smoke detectors the additional automatic II common use spaces. Also, or powered smoke detection of grooms. The fire alarm is					(Ve) PATE	

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

TITLE

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.

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

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG 01 - Main Building 01		(X3) DATE SURVEY COMPLETED		
		245402	B. WING _			02/05/2015		
	ROVIDER OR SUPPLIER OD VILLAGE CARE CEN	TER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
K 000	notification. Because 3 additions are of the type allowed for exist surveyed as one build. The facility has a cap census of 58 at the tire.	the original building and the same type of construction ing buildings, the facility was ding. acity of 64 beds and had a me of the survey. 2 CFR, Subpart 483.70(a) is	K					



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 <u>only a suggestion</u> 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.

Glenwood Village Care Center February 19, 2015 Page 2

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 Weeth

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

Minneso	Minnesota Department of Health			# FORM		
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION E	(X3) DATE SURY COMPLETE	
		00474	B. WING	MAR 0 9 2015	02/04/20	015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STANEUR CODE tment of Health	1 02/04/20	713
GLENW	OOD VILLAGE CARE		THEAST 2N OOD, MN 56			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) DMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall lead to the correcte	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of tlack of compliance. re-inspection with a result in the assessing the requirements of the result in the requirements of the requ	nether a violation has been compliance with all rule provided at the tag le number indicated below. It is several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item tring the initial inspection was				
	that may result from orders provided that the Department with	nearing on any assessments in non-compliance with these tawritten request is made to nin 15 days of receipt of a non-compliance.				
	Department's staff, the following correct corrections are commake a copy of thes original to the Minne	and 4, 2015, surveyors of this visited the above provider and tion orders are issued. When pleted, please sign and date, se orders and return the esota Department of Health, ince Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

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

CEO

TITLE

(X6) DATE

E3HQ11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
		00474	B. WING		02/04/2015		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
GLENWO	OD VILLAGE CARE CEN	TER	THEAST 2ND S' DOD, MN 56334				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE		
2 000	2 000 Continued From page 1		2 000				
	Certification Program Supervisor, 1505 Pet Fergus Falls, 56537.	, Gail Anderson, Unit oble Lake Road, Suite 300,		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule out of compliar listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction ord This column also includes the finding which are in violation of the state star after the statement, "This Rule is not as evidence by." Following the surve findings are the Suggested Method of Correction and Time period for Correction and Time period for Correction and Time period for Corrections." THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	g." nce is ne "To er. is tute met yors of ction. IG OF		
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565				
		nprehensive plan of care ersonnel involved in the					
	by: Based on observation	t is not met as evidenced n, interview and document ed to provide repositioning					

Minnesota Department of Health

STATE FORM 6899 E3HQ11 If continuation sheet 2 of 21

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		00474	B. WING		02/04/2015		
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA				
GLENWO	OD VILLAGE CARE CEN	TER	D, MN 56334	REET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
2 565	Continued From page	2	2 565				
	assistance as directed by the care plan for 1 of 2 residents (R19) in the sample reviewed for positioning.						
	Findings include:						
	R19's quarterly Minim 12/30/2104, indicated pressure related ulcer	R19 was at risk for					
	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.						
	was continuously obs	3 a.m. until 3:03 p.m. R19 erved seated in the and 45 minutes) without					
	(NA)-A stated she wa a.m. to 3:00 p.m. NA what repositioning dir plan but was sure R1 every 2 hours at night been repositioned sin	54 p.m. nursing assistant s assigned to R19 from 6:30 -A stated she was not sure ective was on R19's care 9 was to be repositioned t. NA-A stated R19 had not ce 7:18 a.m. (7 hours and hing and verified R19 had refused repositioning					

Minnesota Department of Health

STATE FORM 6899 E3HQ11 If continuation sheet 3 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00474	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
01 =11140		719 SOUTI	HEAST 2ND ST	REET	
GLENWO	OD VILLAGE CARE CEN	TER GLENWOO	DD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 565	Continued From page	3	2 565		
	On 2/04/2015, at 9:01 worked with R19 on 2 supposed to repositio NA-C also stated R19				
		l 2 p.m. registered nurse 9's care plan and stated R19 d every two hours as			
		11 p.m. RN-B stated she reposition R19 every 2			
	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.				
	The director of nursin review/revise policies care plan implementa could be re-educated for evaluating and moimplementation could	and procedures related to ation. Pertinent employees on these policies. A system politoring consistent care plan be developed, with the se being reviewed by the			

Minnesota Department of Health STATE FORM

TATE FORM E3HQ11 If continuation sheet 4 of 21

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00474	B. WING		02/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
GLENWO	OD VILLAGE CARE CEN	TER	HEAST 2ND ST OD, MN 56334	KEEI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page 4		2 565			
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
2 905	5 MN Rule 4658.0525 Subp. 4 Rehab - Positioning		2 905			
	of residents unable to must be changed at le including periods of ti been put to bed for th has documented that hours during this time	dy alignment. The position ochange their own position				
	by: Based on observation review the facility faile identified at risk for prositioning assistance development of press	t is not met as evidenced n, interview and document ed to ensure residents ressure ulcers received e in order to prevent the sure ulcers for 1 of 2 e sample identified at risk for				
	Findings include:					
	last updated 1/29/201 diagnosed with deme weakness, urinary ind dermatitis, generalize	ntia, diabetes, depression,				

Minnesota Department of Health STATE FORM

E3HQ11 If continuation sheet 5 of 21

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00474	B. WING		02/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1	
GLENWO	OD VILLAGE CARE CEN	TER	HEAST 2ND ST	REET		
		GLENWO	OD, MN 56334		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 905	5 Continued From page 5		2 905			
	10/9/2014, and quarte both indicated R19 ha impairment, utilized a frequently incontinent pressure ulcers and r	mum Data Set (MDS) dated erly MDS dated 12/30/2104, ad severe cognitive urinary catheter, was of bowel, was at risk for equired extensive staff tivities of daily living (ADLs),				
	R19 had an alteration advanced age, decrediabetes and inconsist plan indicated R19 ut mattress, pressure reand directed staff to rehours. The care plan	evised 1/29/2015, indicated in skin integrity related to ased mobility, incontinence, stent repositioning. The care ilized a pressure reducing ducing wheelchair cushion eposition R19 every two identified R19 had a historying, and directed staff to position.				
		Nursing Assistant Care I 1/5/2015, indicated R19 d every 2 hours.				
	cream to head of pen shift since 1/29/15, Ad buttocks and scrotum every day and evenin keep off bottom as mo 12/14/14, lamisilat cre as needed since 10/2 scrotum three times p	to prevent skin breakdown g shift since 1/23/15, to				

Minnesota Department of Health

STATE FORM 6899 E3HQ11 If continuation sheet 6 of 21

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00474	B. WING		02/04/2015	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
GLENWO	DD VILLAGE CARE CEN	TER	HEAST 2ND ST DD, MN 56334	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 905	Continued From page	6	2 905			
	-On 12/19/14, indicate review was completed plan remained appropriate on 1/17/2015, indicate	ted R19 did not want to lay				
	•	sure / assist in healing his ed after encouragement.				
	-On 1/18/2015, indica on his bottom, was sti	ted little improvement noted Il red and sore.				
	indicated A & D Ointm	n treatments. The note also ent was applied to the area with bleeding was				
	was continuously obs	a.m. until 3:03 p.m. R19 erved seated in the nd 45 minutes) without				
	(NA)-A stated she was from 6:30 a.m. to 3:00 not sure what repositing R19's care plan but w repositioned every 2 h R19 had not been rep					

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
	00474	B. WING		02/0	4/2015	
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE CARE CEN	719 SOUTH	RESS, CITY, STA IEAST 2ND ST D, MN 56334				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
worked with R19 on a supposed to reposition felt staff could get him that. NA-C also state issues for the last 6 r R19 was not assisted wheelchair during the hours and 36 minutes. On 02/04/2015, at 2: (RN)-B confirmed R1 conditions and risk the care plan and stated every two hours as divided every two hours as divided every two hours as divided every the computation of the facility of the facility Repositioning (Tissue Policy and Procedure an individualized turn schedule was determed every 2 hours individual needs and teach staff to make salter pressure points use different chairs a	1 a.m. NA-C who also 2/3/15, stated staff were on R19 every 2-3 hours and noff his bottom more than ad R19 has had different skin months. NA-C also confirmed if / repositioned out of his aday shift on 2/3/15, for 7 s. 12 p.m. registered nurse 9's long standing skin here of and verified R19's R19 was to be repositioned irected. RN-B stated she if or refusing repositioning and osed to document the here. 11 p.m. RN-B stated she reposition R19 every 2 didocument if refused. 12 p.m. registered nurse 9's long standing skin here of and verified R19's R19 was to be repositioned irected. RN-B stated she refusing repositioning and osed to document the here. 13 p.m. RN-B stated she reposition R19 every 2 didocument if refused. 14 policy titled Turning and the Tolerance) Observation explicated once hing an repositioning hined the resident would be or more often according to to assist resident and to mall changes in position to every 30 minutes while up, liternately and if resident was expositioning it would be	2 905				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00474	B. WING		02	/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA		, , , , , ,	
GLENWO	OD VILLAGE CARE CEN	TER	HEAST 2ND ST DD, MN 56334	KEEI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 905	The director of nursin staff and perform aud is receiving appropria by the individual care to ensure compliance	OD OF CORRECTION: g or designee could train all its to ensure each resident te nursing care as directed plan and initiate monitoring.	2 905			
21200	TIME PERIOD FOR CORRECTION: Twenty One (21) days. 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		21200			

Minnesota Department of Health

STATE FORM 6899 E3HQ11 If continuation sheet 9 of 21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00474	B. WING		02/04/2015
	ROVIDER OR SUPPLIER	719 SOUT	DRESS, CITY, STA HEAST 2ND ST OD, MN 56334	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
21200	parts per million of ave hypochlorite at a temp degrees Fahrenheit (2000 one minute; or E. for equipment immersion, but in white treatment with steam additives other than to of Federal Regulation. Equipment too large must be rinsed, spray sanitizing solution of a strength for that particular.	a solution containing 50	21200		
	Based on observation review, the facility fail preparation equipmer between each use, to This had the potentia who ate in the facility. Findings include: During the initial kitch a.m. dishes and utens	nt was properly sanitized prevent food borne illness. I to affect 59 of 59 residents			
	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				

Minnesota Department of Health

STATE FORM 6899 E3HQ11 If continuation sheet 10 of 21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00474	B. WING		02	/04/2015	
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	02	70472013	
GLENWOOD VILLAGE CARE CENTER	R	THEAST 2ND ST OD, MN 56334	REET			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
soap, rinsed them off with them to air dry on the dry these items were then eit to be used by other dietadid not know how the warmonitored for rinsing the in the two-compartment in never measured the tem water, and confirmed the measuring the rinse water. During observation of meat 9:35 a.m. a spatula warmat, next to the two-compartment stated that she did not grutensils and bowls using sink. On 2/4/15, at 8:26 a.m. treported it was her expercooks sent all dishes and dish machine, after each manager confirmed C-A food preparation utensils only washing them with I rinsing them under hot witwo-compartment sink, withrough the dish machine.	that they used more than compartment sink. C-A sequipment with Dawn dish the hot water and allowed ying mat. C-A stated ither re-used or put away, any staff. C-A stated she atter temperature was equipment she washed sink. C-A stated she had aperature of the rinse are was no record for er temperature. The dietary manager and the two-compartment sink. C-B enerally wash and re-use of the two-compartment sink. The dietary manager and C-B were re-using and equipment, after Dawn dish soap and water in the without sending them e. The dietary manager of C-A, C-B and C-C not to be send all dishes and lish machine to ensure one Policy dated 5/13, so, silverware and any eaned and sanitized	21200				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
			B. WING		
		00474			02/04/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA HEAST 2ND ST		
GLENWO	OD VILLAGE CARE CEN	TER	OD, MN 56334	NEL I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21200	Continued From page 11		21200		
		ater rinse temperature of 180 =), for proper sanitization.			
	SUGGESTED METH	OD OF CORRECTION:			
	revise policies and prothe three compartment purposes. In addition, staff member could protect the province of the protect of	the (FSD) or designated			
	TIME PERIOD FOR (Twenty-one (21) days				
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375		
	home must establish	control program. A nursing and maintain an infection need to provide a safe and			
	by: Based on interview an facility failed to establ program which includ surveillance of reside surveillance and invesidentified. This had the residents who resided. Findings include: The facility's Infection.	nt symptoms, analysis of the stigation of patterns e potential to affect all 59 d in the facility.			

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viirinesot	a Department of Healtr	<u>.1</u>				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ĒD
		00474	B. WING		02/04/	2245
		00474			02/04/2	2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓΕ, ZIP CODE		
		719 SOUT	HEAST 2ND ST	REET		
GLENWO	OD VILLAGE CARE CEN	ITER	OD, MN 56334			
2(1) ID	SLIMMARY ST		·	PROVIDER'S DI AN OF CORRECTIO	NI .	0(5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
21375	75 Continued From page 12		21375			
2.0.0	Continued From page 12		21070			
	identified and tracked only residents with					
	infections for which antibiotics were prescribed.					
		ince processes also lacked				
		llowing: location of the				
	resident within the fac	cility, specific symptoms that				
	were present, cultures	s performed/ organism				
	identified, specific ant	tibiotic used, and the date				
	the infection resolved	l. Furthermore, the logs				
	lacked analysis and/o	or investigation of patterns				
	identified.					
	During interview on 2	/4/15, at 1:30 p.m. the				
		dinator (ICC) confirmed she				
	did not have any furth	ner documentation to support				
	tracking or trending of	f infections with in the				
	facility. During a follow	w up interview at 1:56 p.m.,				
		onitor antibiotic use in the				
		ICC verified that effectively,				
	_	rogram of surveillance/				
	-	n was being implemented				
		confirmed it should have				
	been.					
		m. the director of nursing				
	-	did not have any further				
	, ,	oport tracking, trending,				
	•	ion of infections with in the				
	, ,	ified it was her expectation				
		tions within the building. The				
		just cleaning surfaces and				
	just tracking antibiotic					
		ed the procedures and				
		facility's infection control				
		ed, but was not provided.				
		,				
	SUGGESTED METH	OD OF CORRECTION:				
		g and/or designee could icies and procedures related				

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to components of the infection control program

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED
		00474	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		719 SOUT	THEAST 2ND ST	REET	
GLENWO	OD VILLAGE CARE CEN	TER GLENWO	OD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21375	Continued From page	e 13	21375		
		oring system to ensure			
	Time Period For Corredays.	ection: Twenty one- (21)			
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 3 Tuberculosis ol	21426		
	maintain a comprehe infection control progressive by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortalit This program must in infection control plan unpaid employees, coresidents, and volunted Health shall provide to regarding implementations.	ram according to the most infection control guidelines. States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). clude a tuberculosis that covers all paid and contractors, students, eers. The Department of echnical assistance ation of the guidelines.			
	by: Based on interview at facility failed to ensure care workers (HCW's	nd document review, the e all residents and health) received 2 step tuberculin of 5 residents (R20) in the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		00474	B. WING		02/0	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GLENWO	OD VILLAGE CARE CEN	TER	HEAST 2ND S1 DD, MN 56334	TREET		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON	(Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From page 14		21426			
	sample and 1 of 5 newly hired employees, trained medical assistant (TMA)-A in the sample.					
	Findings include:					
	R20's 2nd step TST v required.	vas not interpreted as				
	After review of the rec was done for signs ar (TB) for R20 on 1/9/1 to R20 on 1/9/15 and on 1/18/15, however documentation of inte	ed to the facility on 1/9/15. cord, a baseline screening and symptoms of tuberculosis 5. A TST was administered a second step administered the record lacked expretation of the second the TST was not given.				
		lacked all components re workers (HCW's) for a 2 est.				
	of the record, a basel signs and symptoms A TST was administe and the results were further more the form compliance start over to TMA-A on 12/3/14 administered on 12/1 had been working on no baseline screening). A TST was administered				
	During interview on 2	/4/15 at 11:30 a.m. medical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00474	B. WING		02/04/2	2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	,	
GLENWO	OD VILLAGE CARE CEN	TER	IEAST 2ND ST D, MN 56334	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21426		RP)-A confirmed staff were of the TST's in the computer TST was negative or	21426			
	director of nursing (Dipolicy and indicated seriodents a first step and second step TST document results in high paper form. The DON get their first TST on second TST 14 days not allowed to work of and "no I do not think"	e computer and on the I also verified all employees				
	Control Plan, revised will administer a two supon admission and symptoms of TB. The by administrating nursure addate will also be sheets for step one an performed on all emplocontraindicated, upon	TST form will be filled out se. Administration date and added to residents med nd tow of TST. A TST will be				
	The Director of Nursing develop a system to emaintaining an accurate	•				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00474	B. WING		02/04/2015
	OVIDER OR SUPPLIER	719 SOUT	DDRESS, CITY, STATE THEAST 2ND ST OD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
	a random audit tool to	are and services. The ould develop and implement	21426		
	Subp. 2. Emergency nursing home may hamedication supply where the QAA committee. and use of the emergement comply with part of the emergement comply with part of the emergency supply makes and the facility failly emergency supply makes affected 1 of 1 readministered antibiotic expired and had the presidents who were emedications from the findings include: On 2/3/15, at 1:11 p.m. medication cart was murse (RN)-A. One of labeled Cipro (an antifive tablets, with three	ich must be approved by The contents, maintenance, ency medication supply 6800.6700. It is not met as evidenced I, interview and document ed to routinely evaluate edications for expiration, dications from available use. esident (R12) who was comedications that had iotential to affect all 59 ligible to receive facility's emergency supply. In the Station-One eviewed with registered the medication bottles was biotic) 500 milligrams (mg),	21600		

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STATEMENT	<u>a Department of Healtr</u> FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		00474	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
GLENWO	OD VILLAGE CARE CEN	TER	HEAST 2ND ST OD, MN 56334	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21600	Continued From page		21600		
	facility's emergency in the facility's emergency for one-half tablet (250 Cipro from 2/1/15, to the facility's emergency then conducted with in facility's emergency then conducted with in facility's emergency from 10/mg/ml (milliliter)/ in the facility's emergency from vials of Morphine 10/mg/ml (milliliter)/ in the vials of Benadryl medication) 50 mg/ml Four vials of Lasix (a mg/ml/inj, expired 11/1 Two vials of Glucagor very low blood sugar) Two vials of Haldol (a 5 mg/ml/inj, expired 11/1 One bottle of Nitrosta medication which increflow to the heart) 0.4 Five vials of Xylocaine mg/ml/inj, expired 1/1 One bottle of Zithrom medication), six tables buring interview on 2 pharmacy technician medications were laborated as deemed by the man medication. The pharmacy technician medication. The pharmacy technician medication.	act infection. RN-A een administered four doses o mg) each, of the expired 2/3/15. A thorough review of cy medication supply was RN-A, with additional expired d, including the following: e Sulfate (a pain medication) of (injection), expired 1/1/15; (an antihistamine /inj, expired 11/14; diuretic medication) 10 1/14; of (a medication used to treat of expired 10/14; of (a medication used to treat of expired 10/14; of (a medication used to treat of expired 10/14; of (a local anesthetic) 1%, 10 of and of (an antibiotic of (an antibi			

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN C	IND FLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		COMPLETED
		00474	B. WING		02/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CI ENWO	OD VILLAGE CARE CEN	719 SOUT	HEAST 2ND ST	REET	
GLENWOO	OD VILLAGE CARE CEN	GLENWOO	DD, MN 56334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21600	Continued From page	2 18	21600		
	over expired medicati	ON) expressed surprise ons in the emergency led, "[Pharmacy personnel]			
	indicated the usual pr expiration dates of all	acility's supplying pharmacy actice was to review medications in the x whenever a medication			
	1/15, identified the ph	ncy Drug Box policy revised larmacy which owned the in supply, was responsible g that was outdated.			
	SUGGESTED METH	OD OF CORRECTION:			
	pharmacist could development of the DON could delegate the emergency medicassessment and assuments.	ng (DON) and the consulting elop a system to ensure the n supply were not expired. yate nursing staff to monitor eation supply. The quality urance (QA&A) committee the emergency medication e.			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one			
21735	MN Rule 4658.1420	Solid Waste Disposal	21735		
		g garbage, rubbish, r refuse must be collected, of in a manner that will not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		00474	B. WING		02	/04/2015
	ROVIDER OR SUPPLIER OD VILLAGE CARE CEN	719 SOU	DDRESS, CITY, STATE ITHEAST 2ND STR DOD, MN 56334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21735	breeding place for instance Accumulation of com- unassigned areas is put a significant of the com- transfer of the computation	fire hazard, nor provide a sects or rodents. bustible material or waste in prohibited. It is not met as evidenced an, interview and document ed to ensure outside storage intained in a manner which thereby preventing overflow not free from litter and otential to affect all 59	21735			
	facility's dumpster are dumpsters, located to nursing home, near that attached dumpster codumpster units (close pushed up, approxim white/clear garbage be receptacles. Both dur with trash bags. One was observed on the in front of it. On 2/2/15, at 8:16 a.r M-B provided a tour of area. M-A stated the Noon, on Mondays at company. M-A was not that was lying in the sof the overfilled dumpster in the s	ne curb and street. The overs to the first and second				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	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				
PREFIX (EACH DEFICI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
trash that lay on the company spilled be units. M-B added added their trash to were also to be use and other housing same company. My garbage was empto address garbage was empto address garbage keep the grounds. SUGGESTED ME The administrator revise procedures maintenance of the The administrator education and devensure compliance.	trol the volume of trash, or the e ground, as the sanitation ags when they emptied the people who lived in town to the facility's dumpsters, which ed for an assisted living facility units that were owned by the I-B reported some campground ied there as well. THOD OF CORRECTION: THOD OF CORRECTION:	21735	DETICIENCE!)	

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