DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 1, 2023

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

RE: CCN: 245402
Cycle Start Date: January 10, 2023

Dear Administrator:

On February 28, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered

March 1, 2023

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

Re: Reinspection Results
Event ID: FCV712

Dear Administrator:

On February 28, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 10, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2023

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

RE: CCN: 245402
Cycle Start Date: January 10, 2023

Dear Administrator:

On January 10, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 10, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 10, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

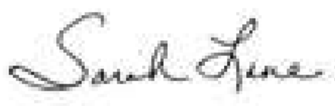
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: FCV711

Dear Administrator:

The above facility was surveyed on January 8, 2023 through January 10, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 01/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/8/23, to 1/10/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/8/23, to 1/10/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H54027242C (MN00084405). The following complaint was found to be SUBSTANTIATED: H54027243C (MN00086116), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/04/2023

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 2 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 3 residents (R13) who received assistance with eating in the Golden Meadows dining room. Findings include: R13's quarterly Minimum Data Set (MDS) dated 11/29/22, identified R13 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, muscle wasting, and dysphagia (swallowing disorder). R13's MDS identified R13 required total assistance with eating. R13's care plan revised 12/5/22, identified R13 had impaired cognitive function and was unable to verbalize any discomfort. R13's care plan identified R13 had self care deficit and required total dependence assist of one for eating. On 1/8/23, at 12:36 p.m. R13 was seated in her high back wheelchair in the dining room. Activity aide (AA)-A approached R13, positioned R13 to a bedside table and proceeded to set up her meal tray. At 12:40 p.m. AA-A sat in a chair next to	F 550	Corrective action will be accomplished for the resident affected by having nursing staff review policy for dignity while dining, purchasing of stools and auditing of effectiveness. All residents have the potential to be affected as all residents receive meals and snacks from the facility. Glenwood Village Care Center will have nursing staff review policy for dignity with dining. Due to having shorter staff, Glenwood Village Care Center will purchase and implement stools for feeding. Monitoring will be conducted during mealtimes through an audit process. Audits will be completed once a week for 4 weeks, Once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI. Completion of corrective action will be done by 2-16-23.	

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F 550	Continued From page 3 R13, said "oh, your chair is so high I will have to stand", stood up and began to feed R13 her meal while standing. AA-A did not attempt to adjust R13's wheelchair at any time so she could have been seated while feeding R13. From 12:40 p.m. to 1:40 p.m., AA-A continued to stand while feeding R13 her meal. Three other staff members were present in the dining room and did not re-direct or assist AA-A with adjusting R13's wheelchair. After R13 finished her meal, AA-A transported her via the wheelchair over to the sitting area next to the dining room. During an interview on 1/9/23, at 4:22 p.m. AA-A confirmed she had fed R13 while standing, and indicated she had attempted to sit, however felt R13's new wheelchair was to high. AA-A stated she was aware she should not feed residents while standing, however stated she had not been trained how to lower R13's wheelchair. During an interview on 1/9/23, at 4:48 p.m. clinical manager (CM)-A stated R13 required total assistance for all cares which included eating. CM-A indicated she would expect staff members to sit next to residents while assisting them with eating. CM-A confirmed staff standing next to a resident while feeding would not be a dignified dining experience. During an interview on 1/9/23, at 5:05 p.m. director of nursing (DON) indicated she would expect staff members to sit during the meal at one of the tables when assisting R13 to eat her meal and confirmed R13 was not fed in a dignified manner. The facility policy titled Dignity During Dining dated 3/23/17, identified the dining experience	F 550		

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F 550	Continued From page 4 would enhance the resident's quality of life and recognized the resident's needs during dining to achieve and maintain the dignity and respect in full recognition of his or her individually. The policy procedure included to sit next to the residents while assisting them to eat, rather than standing over them.	F 550		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		1/31/23

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F 645	Continued From page 5 services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 645	Corrective action for Staff related to	

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F 645	Continued From page 6 review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) level one assessment had been completed for 1 of 3 residents (R27) reviewed for PASRR. Findings include: R27's admission Minimum Data Set (MDS) dated 9/27/22, indicated R27 had moderate cognitive impairment and had diagnoses which included manic depression (bi-polar disease), peripheral vascular disease, hemiplegia or hemiparesis. The MDS identified R27 required one to two staff assistance with all activities of daily living (ADL's). R27's care plan revised on 1/2/23, indicated R27 was at risk for functional impairment related to mood disorder, bipolar disorder, manic depression, use of antidepressants, cognitive impairment and was dependent on staff for ADL's. Review of R27's medical record (MR) lacked a level one PASRR screening had been completed to consider a referral for further evaluation and determination of need for specialized services. During an interview on 1/9/23, at 3:22 p.m. medical records employee (MRE) confirmed R27's MR lacked a level one PASRR. MRE indicated it was the social workers responsibility to ensure the PASRR's were being completed as required. During an interview on 1/9/23, at 3:38 p.m. the social worker designee (SWD) indicated it was her responsibility to ensure the PASRR's were being completed on admission. The SWD	F 645	PASARR includes updating facility process and audits. All residents could be potentially be affected as there may be a need for a higher level of care for their health. Facility to review procedure for admissions. Social worker will ask for submitted PASARR screening prior to resident admitting to the nursing home. Social worker will review PASARR and request a final copy be faxed to her. Social worker will add section to the care plan. Education to be provided to all staff included in the admission process. Facility will update their admission checklist to include items such as assuring PASSR was completed and Filed for Social Services. Audit will be conducted on all current residents to assure PASARR s are completed and filed. Audits of PASARR screening will be completed once a week for 4 weeks, Once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI. Corrective Action will be completed by February 16th, 2023.	

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F 645	Continued From page 7 confirmed R27's MR lacked a level one PASRR. During an interview on 1/9/23, at 3:41 p.m. the director of nursing (DON) confirmed the above findings. The DON indicated she would expect staff would ensure a level one PASRR to be completed prior to admission and to follow the facility policy. Review of the facility policy titled, Comprehensive Care Plans revised on 10/14/22, identified a PASRR for orientation, mood and behaviors would be completed for each resident.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with routine grooming which included facial hair removal and changing soiled clothing for 1 of 1 residents (R43) who was dependent upon staff for activities of daily living (ADLs). Findings include: R43's quarterly Minimum Data Set (MDS), dated 10/4/22, identified R43 had sever cognitive impairment and had diagnoses which included Alzheimer's disease, generalized muscle weakness and hypertension. The MDS indicated R43 required extensive assistance of staff for bed mobility, transfers, dressing, toileting, bathing and	F 677	Corrective action for Staff related to dependent residents who receive ADL care includes Education, audits, and reviews. All residents are at risk to be affected as staff provide ADL cares to all our residents. Facility will correct the deficiency as it relates to the individual AEB assuring his care plan is up to date and reviewed by the clinical staff. A policy will be developed and implemented related to adls. Staff will be trained on policy r/t ADLs.	2/1/23

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F 677	Continued From page 8 personal hygiene. R43's care plan revised on 1/6/23, indicated R43 had impaired functional status related to diagnosis of hypertension, Alzheimer's disease, dementia, muscle weakness and dependence in ADL's. The care plan indicated staff were to assist R43 with dressing and grooming. The care plan indicated staff were to shave R43's chin hairs daily and as needed. The care plan identified R43 would become agitated while shaving and staff would need to perform multiple sessions to complete a thorough shaving. During observations on 1/8/23, from 3:20 p.m. to 7:30 p.m., R43 was seated in his wheel chair propelling himself around the unit. R43 wore a black pair of pants which had several large soiled white spots/smudges on the upper thighs of his pants. R43 had several long white hairs approximately 1/4 inch long or longer under his nose area, on the sides of his mouth, on the lower side of his jaw bones and stubbles noted to be present all over the rest of his face. R43 continued to wear the same black pants and remained unshaven all evening until approximately 7:30 p.m. During observations on 1/9/23, from 9:14 a.m. to 6:03 p.m., R43 was seated in his wheel chair in the dining room area with other residents eating his breakfast independently. R43 continued to be wearing the same black pair of pants which had several large soiled white spots/smudges on the upper thighs of his pants. R43 continued to have several long white hairs approximately 1/4 inch long or longer under his nose area, on the sides of his mouth, on the lower side of his jaw bones and stubbles present all over the rest of his face.	F 677	Audits of ADL care will be completed once a week for 4 weeks, Once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI. Completion of corrective action will be done by 2-16-23.	

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F 677	Continued From page 9 - at 12:06 p.m. R43 was seated in his wheel chair out in the dining room area with other residents eating his lunch independently and continued to wear the same soiled pair of black pants and remained unshaven. - at 12:37 p.m. R43 was seated in his wheel chair out in the dining room area with other residents and remained the same. - at 12:40 p.m. nursing assistant (NA)-B approached R43, asked if he would like more chocolate milk, R43 indicated he would and NA-B provided him with another glass of chocolate milk and exited the dining room area. - at 12:52 p.m. NA-C approached R43, asked him if he was done eating, assisted him in wiping his face and left the dining room area. - at 1:01 p.m. R43 began to propel his wheelchair with his feet independently down the hallway. R43 briefly stopped and visited with laundry staff that was delivering linen. - at 1:02 p.m. NA-D walked by R43 and said hi to him. - at 1:06 p.m. R43 was seated in his wheel chair up at the dining room table and his pants remained the same and he continued to be unshaven. - at 1:16 p.m. activity aid (AA)-A approached R43 and asked him what he ate for lunch. The AA-A proceeded to glove her hands, warmed up R43's food from lunch, sat down next to him and began feeding him bites of ham. - at 1:33 p.m. AA-A wheeled R43 down to the sitting area on the 200 wing and they began playing a balloon game on the TV with another resident. - at 2:15 p.m. R43 was propelling himself around the Blue Horizon unit in his wheel chair when clinical manager (CM)-C briefly stopped and went up to R43 and said "I like your outfit" and	F 677		

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F 677	Continued From page 10 immediately walked away. R43's pants remained the same and he continued to be unshaven. - at 4:00 p.m. R43 was seated in his wheel chair out in the dining room area with other residents. R43 continued to wear the same black pair of pants although now he had several large soiled red and white spots/smudges on the upper thighs of his pants and several red smudges on the belly area of his black and white plaid shirt and he remained unshaven. - at 6:03 p.m. R43 remained the same. During an interview on 1/9/23, at 6:03 p.m. NA-A confirmed R43 required staff assistance with ADL's, shaving and dressing. NA-A verified R43's pants and shirt were visible soiled and indicated staff should have changed his clothing. NA-A indicated staff were suppose to shave R43 on a daily basis and indicated she had shaved R43 on Saturday morning, although he was being a little feisty. NA-A further indicated when R43 was being feisty staff are let him be and re-approach and try again later or try another staff member. NA-A indicated she had not offered to shave R43 again and this should have been done. During an interview on 1/9/23, at 6:05 p.m. licensed practical nurse (LPN)-A confirmed the above findings and indicated R43 required staff assistance with all of his ADL's. LPN-A indicated she would expect staff to change his clothes when they are visibly soiled and assist him with shaving. LPN-A indicated she would expect R43 to be neat and clean and well groomed. During interview on 1/10/23, at 11:13 a.m. the director of nursing (DON) confirmed the above findings and indicated R43 needed staff	F 677		

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F 677	Continued From page 11 assistance with all of his ADL's. The DON indicated she expected staff to assist residents with shaving, grooming, personal hygiene and changing of their clothes when visibly soiled. The DON indicated R43 does refuse cares at times, although staff should re-approach or try different staff and she would expect staff to follow the the care plan. Review of facility policy titled, Shaving Residents dated 4/20/17, indicated men shall be shaved every day. Each resident shall provide their own electric razor. On 1/10/23, a policy regarding providing ADL's was requested and one was not provided.	F 677		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		1/31/23

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F 732	Continued From page 12 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 50 residents who resided in the facility and/or any visitors who may have wished to view the information. Findings included: Review of the Daily Staffing Report (located in a clear plastic sleeve on a board near the entrance of the facility) on 1/8/23, at 11:39 a.m. revealed the following: The report was dated for 1/3/23, and identified a census of 53 when the current census was 50. -at 3:48 p.m., the staff posting remained the same. -at 8:05 p.m., the staff posting remained the same.	F 732	Corrective action for Staff related to Posting Daily Nursing Staff Census Sheet includes process change and education. All residents are at risk to be affected as they need information related to staffing hours. Scheduler to print out census sheets for the weekend. Census Sheets will be put in a designated area. NOC Charge nurse to change out or update the Staff posting at the door. Education provided to the Charge Nurses on how to properly fill out and change a sheet. Audits of Staff positing will be completed once a week for 4 weeks, once a Month for 3 months, and will continue until compliance has been met. Any concerns	

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F 732	Continued From page 13 During an observation on 1/9/23, at 7:45 a.m. the facility's Daily Staffing Report continued to be dated 1/3/23, and identified a census of 53. During an interview on 1/10/23, at 10:51 a.m. the staff scheduler (SS) confirmed the above findings and indicated she was responsible to ensure the staff posting was updated on a daily basis from Monday to Friday. SS indicated she was not certain who updated the reports when she was not in the building. The SS stated she would expect the staff posting to be updated daily to reflect the changes with staffing and census. During an interview on 1/10/23, at 10:58 a.m. the director of nursing (DON) confirmed the above findings and indicated her expectation of staff would be for the staff posting to be completed daily and to reflect the current staffing pattern and census. Review of the facility policy titled, Posting Daily Nursing Staff Schedule dated 3/23/17, indicated the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents and resident census. The policy identified the posting of direct care daily staffing numbers would be posted within two hours of the beginning of each shift.	F 732	will be reviewed at QAPI. Completion of corrective action will be done by 2-16-23.	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		1/31/23

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F 804	Continued From page 14 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 2 residents (R 21 and R26) who resided on Blue Horizon unit and Ruby Ridge unit reviewed for food. This had the potential to affect all 29 residents residing on these units. Findings include: R21's MDS indicated R21 had intact cognition and was able to feed herself after staff set up her tray. R26's MDS indicated R26 had intact cognition and was able to feed herself after staff set up her tray. During an interview on 1/8/23, at 1:30 p.m. R 21 stated the food did not taste very good and the vegetables were hard. During an interview on 1/8/23, at 3:23 p.m. R26 stated the food was often cold and tasted very bland. R26 indicated she had her family bring in food at times. On 1/9/23, at 11:42 food was brought to the steam table and meal service began on the unit. On 1/9/23, at 12:20 p.m. during the noon meal R26 stated her food was a little cold today and	F 804	Corrective action for Staff related to Palatable/Prefer Temp will include education, surveys and audits. All residents are at risk to be affected as all residents eat meals at the facility. Policies will be reviewed. Staff will receive education on current policies, acceptable temps for food, operation of steam tables and proper transportation of food to steam table. Food surveys will be distributed to residents randomly and Concerns & Interventions will be discussed during Food Group. Audits of acceptable meal temps and audits of meals via test trays will be completed once a week for 4 weeks, once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI. Completion of corrective action will be done by 2-16-23.	

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F 804	Continued From page 15 R21 stated the vegetables were hard. On 1/9/23, at 12:23 p.m. a test tray was requested from dietary assistant (DA)-A from the steam table. The meal consisted of ham and sweet potatoes. The ham was barely warm and had some flavor. The sweet potatoes were cold, hard, and lacked flavor. DA-A confirmed the ham was cold and the sweet potatoes were cold and hard. Another test tray was requested from the steam table and the temps were noted to be as follows: - ham was 123 degrees Fahrenheit (F). - sweet potatoes were 122 degrees F. During an interview on 1/9/23, at 12:27 p.m. DA stated she was not aware of the resident's concern of cold food. DA-A confirmed the above finding of improper temperature of food. DA-A indicated the steam table was plugged in and was working. During an interview on 1/9/23, at 1:15 p.m. dietary manager (DM) stated her expectation would have been all hot food should have been kept at least 135 degrees on the steam table. DM indicated if any food was not the correct temperature, staff were expected to reheat it to the appropriate temperature or obtain new food that was at the appropriate temperature. A facility policy titled Food Temperature dated 2010, indicated all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit. The policy identified temperatures should be taken periodically to ensure hot foods stayed above 135 degrees F.	F 804		

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F 881	Continued From page 16	F 881		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to help reduce unnecessary antibiotic use and reduce potential drug resistance for 1 of 5 residents (R29) reviewed for unnecessary medication. Findings include: The Center's for Disease Control and Prevention (CDC)'s Core Elements Of Antibiotic Stewardship For Nursing Homes, dated 2015, included recommendations to identify clinical situations which may be driving inappropriate use of antibiotics and implement specific interventions to improve use, as well as pharmacists could provide assistance in ensuring antibiotics were ordered appropriately. R29's significant change Minimum Data Set (MDS) dated 11/15/22, identified R29 had moderate cognitive impairment with diagnoses which included: heart failure, chronic kidney disease and depression. Identified R29 had received antibiotics seven of the last seven days.	F 881	Corrective action for Staff related to Antibiotic Stewardship will include education to nursing staff and providers, review of policy, change in procedure, and education to providers. All residents are at risk to be affected as residents with prophylaxis use of long standing antibiotics are at a higher chance of developing antibiotic resistant issues. Antibiotic stewardship policy education reviewed with nurses, Rounding Doctors and Medical Director. Review of long-time use antibiotics to be completed and indication requests to be sent out yearly. Initial Review of current residents on long time use antibiotic will be conducted. Audit of new admissions for antibiotic use will happen once a week for 4 weeks, once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI.	1/31/23

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F 881	Continued From page 17 Review of R29's Medication Review Report signed 12/22/22, identified R29's orders included: -clindamycin HCL (antibiotic) capsule 150 mg (milligrams), give 1 capsule orally (by mouth) two times a day for lifetime suppression, with start date of 11/17/21, and no end date. Review of R29's Pharmacist Recommendations To Providers dated 11/15/22, identified R29 continued clindamycin 150 mg two times a day for lifetime infection suppression with history of infected total knee arthroplasty (total knee replacement) (TKA). The form identified the recommendation to support continued use of long-term antibiotic use and to document a risk versus benefit statement in upcoming visit note for antibiotic stewardship purposes. Review of R29's physician visit and clinic notes dated 12/23/21, to 12/22/22, revealed the following: -12/23/21, lacked documentation regarding long term use of clindamycin. -1/26/22, lacked documentation regarding long term use of clindamycin. -2/10/22, lacked documentation regarding long term use of clindamycin. -3/2/22, lacked documentation regarding long term use of clindamycin. -3/8/22, lacked documentation regarding long term use of clindamycin. -4/27/22, included statement "history of chronic antibiotic use and it is not clear to me why he is on lifetime clindamycin. I will have to review his past medical history and see if that should be continued". -6/22/22, lacked documentation regarding long term use of clindamycin. -8/25/22, lacked documentation regarding long	F 881	Completion of corrective action will be done by 2-16-23.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 18	F 881		

term use of clindamycin.
-10/13/22, lacked documentation regarding long term use of clindamycin.
-12/22/22, lacked documentation regarding long term use of clindamycin and lacked risk versus benefit statement.

During a telephone interview on 1/10/23, at 12:57 p.m. clinical pharmacist (CP)-A confirmed R29 received clindamycin on a long term basis. CP-A verified on 11/15/22, a pharmacy recommendation had been made to R29's primary care physician (PCP)-A to document risks versus benefits for continued use of the Clindamycin. CP-A indicated long term use of antibiotics was not recommended, however indicated typically the only time it was used was for orthopedic (branch of medicine for bones and muscle) reasons. CP-A stated the risks versus benefits for continued use should have been documented annually.

During a telephone call on 1/10/23, at 1:11 p.m. a call was made to R29's previous PCP, who had originally ordered the antibiotic, and was informed by the clinic office nurse (CON)-A he had retired. CON-A stated R29 had last been seen by her orthopedic surgeon in April of 2021. At 1:15 p.m. the telephone call was transferred to PCP-A's nurse, and a voice message was left for a return call. No return call was received.

During a joint interview on 1/10/23, at 11:47 a.m. director of nursing (DON) and clinical manager (CM)-B both confirmed R29 received clindamycin for prophylaxis and a risk versus benefit assessment for continued use had not been completed. DON confirmed prophylactic antibiotic use was not recommended as it could cause

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	245402	A. BUILDING _____ B. WING _____	C 01/10/2023

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F 881	Continued From page 19 resistance to bacterial agents. During a follow up interview on 1/10/23, at 2:24 p.m. DON indicated she would expect the clinical manger to assure R29's pharmacy recommendation was addressed. The facility policy titled Antibiotic Stewardship reviewed 9/23/21, identified the facility antibiotic stewardship program promoted the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and the reduction of antibiotic resistance. The policy procedures included if antibiotics were ordered, the practitioner would identify the diagnoses/indication, the right antibiotic, proper dose, duration and route. The policy identified if in the event the prescribing physician orders an antibiotic without identification of infection criteria, the physician would be requested to identify the rationale for ordered antibiotic and the medical director would be contacted for further direction. The policy further identified if a resident was admitted to the facility with an antibiotic ordered, the nurse would identify the indication for use, documentation for dose, route and duration (ensuring a stop date). The policy indicated the infection preventionist would track antibiotic use and monitor adherence to evidence-based criteria. The policy identified the facility would ensure that prescribing practitioners would document periodic review of antibiotic use to monitor appropriate prescribing.	F 881		

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	245402	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/17/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/17/2023. At the time of this survey, Glenwood Village Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Glenwood Village Care Center was constructed at five different times. The original building was built in the 1962, is 1- story, with a partial basement and was determined to be of a Type II (111) construction. In 1975 an addition was added to the northeast that was determined to be Type II (111) construction. In 1978 an addition was added to the southeast that was determined to be Type II (111) construction. In 1987 an addition was added to the west that was determined to be Type II(111). In 2014 the 1987 addition was renovated into a 15 bed southwest wing. Type II (III) construction. The building is divided into 6 smoke zones on the main floor. The facility is now surveyed as one facility. An automatic sprinkler system is installed throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces. Also, the facility has battery powered	K 000		

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

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

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K 000	Continued From page 1 smoke detection in all resident sleeping rooms. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 50 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/8/23, to 1/10/23, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0920, 0960, 1805.	2 000		

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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H54027242C (MN00084405). The following complaint was found to be SUBSTANTIATED: H54027243C (MN00086116), however NO licensing orders were issued due to actions implemented by the facility prior to survey. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with routine grooming which included facial hair removal and changing soiled clothing for 1 of 1 residents (R43) who was dependent upon staff for activities of daily living (ADLs). Findings include: R43's quarterly Minimum Data Set (MDS), dated	2 920	Corrective action for Staff related to dependent residents who receive ADL care includes Education, audits, and reviews. All residents are at risk to be affected as staff provide ADL cares to all our residents. Facility will correct the deficiency as it	1/31/23

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2 920	Continued From page 3 10/4/22, identified R43 had sever cognitive impairment and had diagnoses which included Alzheimer's disease, generalized muscle weakness and hypertension. The MDS indicated R43 required extensive assistance of staff for bed mobility, transfers, dressing, toileting, bathing and personal hygiene. R43's care plan revised on 1/6/23, indicated R43 had impaired functional status related to diagnosis of hypertension, Alzheimer's disease, dementia, muscle weakness and dependence in ADL's. The care plan indicated staff were to assist R43 with dressing and grooming. The care plan indicated staff were to shave R43's chin hairs daily and as needed. The care plan identified R43 would become agitated while shaving and staff would need to perform multiple sessions to complete a thorough shaving. During observations on 1/8/23, from 3:20 p.m. to 7:30 p.m., R43 was seated in his wheel chair propelling himself around the unit. R43 wore a black pair of pants which had several large soiled white spots/smudges on the upper thighs of his pants. R43 had several long white hairs approximately 1/4 inch long or longer under his nose area, on the sides of his mouth, on the lower side of his jaw bones and stubbles noted to be present all over the rest of his face. R43 continued to wear the same black pants and remained unshaven all evening until approximately 7:30 p.m. During observations on 1/9/23, from 9:14 a.m. to 6:03 p.m., R43 was seated in his wheel chair in the dining room area with other residents eating his breakfast independently. R43 continued to be wearing the same black pair of pants which had several large soiled white spots/smudges on the	2 920	relates to the individual AEB assuring his care plan is up to date and reviewed by the clinical staff. A policy will be developed and implemented related to adls. Staff will be trained on policy r/t ADLs. Audits of ADL care will be completed once a week for 4 weeks, Once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI. Completion of corrective action will be done by 2-16-23.	

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2 920	Continued From page 4 upper thighs of his pants. R43 continued to have several long white hairs approximately 1/4 inch long or longer under his nose area, on the sides of his mouth, on the lower side of his jaw bones and stubbles present all over the rest of his face. - at 12:06 p.m. R43 was seated in his wheel chair out in the dining room area with other residents eating his lunch independently and continued to wear the same soiled pair of black pants and remained unshaven. - at 12:37 p.m. R43 was seated in his wheel chair out in the dining room area with other residents and remained the same. - at 12:40 p.m. nursing assistant (NA)-B approached R43, asked if he would like more chocolate milk, R43 indicated he would and NA-B provided him with another glass of chocolate milk and exited the dining room area. - at 12:52 p.m. NA-C approached R43, asked him if he was done eating, assisted him in wiping his face and left the dining room area. - at 1:01 p.m. R43 began to propel his wheelchair with his feet independently down the hallway. R43 briefly stopped and visited with laundry staff that was delivering linen. - at 1:02 p.m. NA-D walked by R43 and said hi to him. - at 1:06 p.m. R43 was seated in his wheel chair up at the dining room table and his pants remained the same and he continued to be unshaven. - at 1:16 p.m. activity aid (AA)-A approached R43 and asked him what he ate for lunch. The AA-A proceeded to glove her hands, warmed up R43's food from lunch, sat down next to him and began feeding him bites of ham. - at 1:33 p.m. AA-A wheeled R43 down to the sitting area on the 200 wing and they began playing a balloon game on the TV with another resident.	2 920		

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2 920	Continued From page 5 - at 2:15 p.m. R43 was propelling himself around the Blue Horizon unit in his wheel chair when clinical manager (CM)-C briefly stopped and went up to R43 and said "I like your outfit" and immediately walked away. R43's pants remained the same and he continued to be unshaven. - at 4:00 p.m. R43 was seated in his wheel chair out in the dining room area with other residents. R43 continued to wear the same black pair of pants although now he had several large soiled red and white spots/smudges on the upper thighs of his pants and several red smudges on the belly area of his black and white plaid shirt and he remained unshaven. - at 6:03 p.m. R43 remained the same. During an interview on 1/9/23, at 6:03 p.m. NA-A confirmed R43 required staff assistance with ADL's, shaving and dressing. NA-A verified R43's pants and shirt were visible soiled and indicated staff should have changed his clothing. NA-A indicated staff were suppose to shave R43 on a daily basis and indicated she had shaved R43 on Saturday morning, although he was being a little feisty. NA-A further indicated when R43 was being feisty staff are let him be and re-approach and try again later or try another staff member. NA-A indicated she had not offered to shave R43 again and this should have been done. During an interview on 1/9/23, at 6:05 p.m. licensed practical nurse (LPN)-A confirmed the above findings and indicated R43 required staff assistance with all of his ADL's. LPN-A indicated she would expect staff to change his clothes when they are visibly soiled and assist him with shaving. LPN-A indicated she would expect R43 to be neat and clean and well groomed.	2 920		

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2 920	Continued From page 6 During interview on 1/10/23, at 11:13 a.m. the director of nursing (DON) confirmed the above findings and indicated R43 needed staff assistance with all of his ADL's. The DON indicated she expected staff to assist residents with shaving, grooming, personal hygiene and changing of their clothes when visibly soiled. The DON indicated R43 does refuse cares at times, although staff should re-approach or try different staff and she would expect staff to follow the the care plan. Review of facility policy titled, Shaving Residents dated 4/20/17, indicated men shall be shaved every day. Each resident shall provide their own electric razor. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to resident assistance activities of daily living. The DON or designee, could provide training for all nursing staff related assisting residents activities of daily living. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced	2 960		2/4/23

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2 960	Continued From page 7 by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 2 residents (R 21 and R26) who resided on Blue Horizon unit and Ruby Ridge unit reviewed for food. This had the potential to affect all 29 residents residing on these units. Findings include: R21's MDS indicated R21 had intact cognition and was able to feed herself after staff set up her tray. R26's MDS indicated R26 had intact cognition and was able to feed herself after staff set up her tray. During an interview on 1/8/23, at 1:30 p.m. R 21 stated the food did not taste very good and the vegetables were hard. During an interview on 1/8/23, at 3:23 p.m. R26 stated the food was often cold and tasted very bland. R26 indicated she had her family bring in food at times. On 1/9/23, at 11:42 food was brought to the steam table and meal service began on the unit. On 1/9/23, at 12:20 p.m. during the noon meal R26 stated her food was a little cold today and R21 stated the vegetables were hard. On 1/9/23, at 12:23 p.m. a test tray was requested from dietary assistant (DA)-A from the steam table. The meal consisted of ham and sweet potatoes. The ham was barely warm and had some flavor. The sweet potatoes were cold,	2 960	Corrective action for Staff related to Palatable/Prefer Temp will include education, surveys and audits. All residents are at risk to be affected as all residents eat meals at the facility. Policies will be reviewed. Staff will receive education on current policies, acceptable temps for food, operation of steam tables and proper transportation of food to steam table. Food surveys will be distributed to residents randomly and Concerns & Interventions will be discussed during Food Group. Audits of acceptable meal temps and audits of meals via test trays will be completed once a week for 4 weeks, once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at QAPI. Completion of corrective action will be done by 2-16-23.	

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2 960	Continued From page 8 hard, and lacked flavor. DA-A confirmed the ham was cold and the sweet potatoes were cold and hard. Another test tray was requested from the steam table and the temps were noted to be as follows: - ham was 123 degrees Fahrenheit (F). - sweet potatoes were 122 degrees F. During an interview on 1/9/23, at 12:27 p.m. DA stated she was not aware of the resident's concern of cold food. DA-A confirmed the above finding of improper temperature of food. DA-A indicated the steam table was plugged in and was working. During an interview on 1/9/23, at 1:15 p.m. dietary manager (DM) stated her expectation would have been all hot food should have been kept at least 135 degrees on the steam table. DM indicated if any food was not the correct temperature, staff were expected to reheat it to the appropriate temperature or obtain new food that was at the appropriate temperature. A facility policy titled Food Temperature dated 2010, indicated all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit. The policy identified temperatures should be taken periodically to ensure hot foods stayed above 135 degrees F. SUGGESTED METHOD OF CORRECTION: The RD or designee could develop policies and procedures to ensure foods are served at the proper temperature to ensure palatability. The RD or designee could educate all appropriate staff on these policies and procedures and could develop a monitoring systems to ensure ongoing compliance.	2 960		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 960	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 3 residents (R13) who received assistance with eating in the Golden Meadows dining room. Findings include: R13's quarterly Minimum Data Set (MDS) dated 11/29/22, identified R13 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, muscle wasting, and dysphagia (swallowing disorder). R13's MDS identified R13 required total assistance with eating. R13's care plan revised 12/5/22, identified R13 had impaired cognitive function and was unable to verbalize any discomfort. R13's care plan identified R13 had self care deficit and required total dependence assist of one for eating. On 1/8/23, at 12:36 p.m. R13 was seated in her	21805	Corrective action will be accomplished for the resident affected by having nursing staff review policy for dignity while dining, purchasing of stools and auditing of effectiveness. All residents have the potential to be affected as all residents receive meals and snacks from the facility. Glenwood Village Care Center will have nursing staff review policy for dignity with dining. Due to having shorter staff, Glenwood Village Care Center will purchase and implement stools for feeding. Monitoring will be conducted during mealtimes through an audit process. Audits will be completed once a week for 4 weeks, Once a Month for 3 months, and will continue until compliance has been met. Any concerns will be reviewed at	2/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 01/10/2023

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21805	Continued From page 10 high back wheelchair in the dining room. Activity aide (AA)-A approached R13, positioned R13 to a bedside table and proceeded to set up her meal tray. At 12:40 p.m. AA-A sat in a chair next to R13, said "oh, your chair is so high I will have to stand", stood up and began to feed R13 her meal while standing. AA-A did not attempt to adjust R13's wheelchair at any time so she could have been seated while feeding R13. From 12:40 p.m. to 1:40 p.m., AA-A continued to stand while feeding R13 her meal. Three other staff members were present in the dining room and did not re-direct or assist AA-A with adjusting R13's wheelchair. After R13 finished her meal, AA-A transported her via the wheelchair over to the sitting area next to the dining room. During an interview on 1/9/23, at 4:22 p.m. AA-A confirmed she had fed R13 while standing, and indicated she had attempted to sit, however felt R13's new wheelchair was to high. AA-A stated she was aware she should not feed residents while standing, however stated she had not been trained how to lower R13's wheelchair. During an interview on 1/9/23, at 4:48 p.m. clinical manager (CM)-A stated R13 required total assistance for all cares which included eating. CM-A indicated she would expect staff members to sit next to residents while assisting them with eating. CM-A confirmed staff standing next to a resident while feeding would not be a dignified dining experience. During an interview on 1/9/23, at 5:05 p.m. director of nursing (DON) indicated she would expect staff members to sit during the meal at one of the tables when assisting R13 to eat her meal and confirmed R13 was not fed in a dignified manner.	21805	QAPI. Completion of corrective action will be done by 2-16-23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21805	Continued From page 11 The facility policy titled Dignity During Dining dated 3/23/17, identified the dining experience would enhance the resident's quality of life and recognized the resident's needs during dining to achieve and maintain the dignity and respect in full recognition of his or her individually. The policy procedure included to sit next to the residents while assisting them to eat, rather than standing over them. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement systems to ensure resident dignity is maintained. The facility could educate all staff on these systems. Random audits for dignity could be done to ensure ongoing compliance. The administrator or designee could take that audit results to the quality assurance group for review and further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		