Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: April 24, 2025

Dear Administrator:

On April 24, 2025, 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 July 24, 2025 (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 October 24, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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Electronically delivered
May 13, 2025

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: State Nursing Home Licensing Orders
Event ID: JQJ811

Dear Administrator:

The above facility was surveyed on April 21, 2025 through April 24, 2025 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/21/25 through 4/24/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		5/23/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct exercises to test their emergency preparedness program (EPP) plan at least twice per year. This had the potential to affect all 29 clients who currently resided in the facility, along with staff who work in the facility. Findings include: Review of the facility's EPP identified the facility failed to conduct exercises to test the emergency plan at least twice per year. Evidence of training for a community-based exercise titled "Response Team, Assemble!" was presented. However, there was no evidence of a second exercise conducted. During an interview on 4/23/25, at 3:38 p.m., administrator stated the facility had the one exercise that was provided, there was no other exercises conducted. A facility policy regarding emergency preparedness exercises and drills was requested but not received.	E 039	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does conduct emergency preparedness exercises at least twice per year. The facility completed an Elopement Drill on 5/22/25. A date for a Table top exercise has been schedule for 2025. All residents and staff have the potential to be affected in the event of an emergency. Staff were trained on EOP protocols and the importance of retaining documentation. Administrator or Designee to track and log emergency exercises quarterly and process results forwarded to the QAA committee for review.	

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F 000	INITIAL COMMENTS On 4/21/25 through 4/24/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. : H 53603207C/MN 00111095. 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 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		

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F 000	Continued From page 11	F 000		

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F 000	Continued From page 12	F 000		

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F 000	Continued From page 13	F 000		

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F 000	Continued From page 14	F 000		
	On 4/21/25, through 4/24/25, a standard survey was completed at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B and requirements for Long Term Care Facilities. The following complaint was reviwed with no deficiencies cited. H53603207C/MN00111095			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-	F 622		5/23/25

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F 622	Continued From page 15 (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622		

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F 622	Continued From page 16 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a	F 622		

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F 622	Continued From page 17 copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide complete information upon transfer to the receiving facility for 1 of 2 residents (R18) reviewed for hospitalization and discharge. Findings include: R18's quarterly Minimum Data Set (MDS) dated 4/10/25, indicated R18 had impaired cognition and was noted to exhibit inattention and disorganized thinking. R18 was also noted to have intermittent behavioral symptoms including physical behavioral symptoms directed towards others, verbal behaviors, and other symptoms not directed at others. R18 was noted to receive assistance with activities of daily living, although was able to ambulate independently. R18's medical diagnoses included acute kidney failure, renal insufficiency, heart failure, hypertension (high blood pressure), Alzheimer's disease, dementia, and depression. A review of Resident Census was completed and it was noted R18 was hospitalized on 3/8/25, however, R18's narrative notes lacked indication as to reason for transfer or what symptoms occurred prior to transfer to the hospital. Upon review of the Resident Census, it was identified resident was returned to the facility on 3/9/25. A review of the narrative progress notes identified documentation from 3/7/25 at 11:37 a.m., which	F 622	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does provide complete documentation and medical history during a resident transfer. Resident #18s transfer documentation was corrected and updated in the record. All residents have the potential to be affected. Audit of all residents transferred in last 30 days was completed. No further discrepancies noted. Policy was reviewed, re-educated nurses on discharge and transfer documentation; implemented checklist for required documents. DON or Designee will audit 100% of transfers weekly x4 weeks, then monthly x2, process results forwarded to the QAA committee for review.	

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F 622	Continued From page 18 identified a fax was sent to the provider to review the rationale for the use of Seroquel (an antipsychotic medication-a medication to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking). The note indicated the provider was also consulted regarding the possibility of a gradual dose reduction (GDR) at that time. The next narrative note on 3/9/25 at 7:07 p.m., identified R18 was hospitalized however, offered no further information. A subsequent note of 3/9/25 at 1:38 p.m., indicated R18 was hospitalized and was treated for dehydration. The note further indicated orders were received in follow up for physical and occupational therapy. During interview on 4/24/25 at 3:44 p.m., the assistant director of nursing (ADON) stated R18 was transferred to the emergency room/hospital for evaluation following a fall. A review of the narrative notes with ADON verified there were no notes which reflected the course of events from 3/7/25 to 3/9/25. On 4/24/25, at 4:37 p.m. an interview was held with the director of nursing (DON) to inquired of the circumstances prior to the transfer to the emergency room/hospital. The DON stated R18 had a fall and struck her head. This was identified on the fall and risk management note. R18 was sent in for evaluation and was treated for dehydration. DON stated R18 was sent in for evaluation by a contract (agency staff). DON stated there should have been a narrative progress note to reflect R18's status leading up to the transfer, and additional documentation to indicate the transfer and report to the receiving facility. A review of the scanned documents was completed with the DON with no documentation	F 622		

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F 622	Continued From page 19 within the record to provide this information. A document, titled SNF/NF to Hospital Transfer Form was provided to surveyor and was informed by DON this was the information sent to the hospital with R18. This document was completed by registered nurse (RN)-A on 3/8/25 at 12:00 p.m. Although signed off as completed at 12:00 p.m., vital signs were completed within the document at 12:35 p.m.. At that time, R18's blood pressure was 80/54 and a heart rate of 85 beats per minute. The diagnoses provided on the transfer form indicated only chronic obstructive lung disease (a lung problem which causes difficulty breathing) and dementia. The transfer lacked information of acute kidney failure, renal insufficiency, heart failure, hypertension, Alzheimer's disease, and depression. The document identified R18's most recent pain level was at nine on a scale of one to ten, with ten being the worst pain, however, lacked information as to when the last pain medication was given. The documentation on the form lacked nutritional information, and failed to indicate R18 received a nutritional supplement. The section for medications lacked any medication information. Within the course of the document, there is a page, titled Acute Care Transfer Document Checklist. Although the resident's name, facility name and phone number were present, there was no other information documented as being sent. The options to send information and check off included the R18's Face Sheet (Document which has all medical diagnoses, contact information, and demographic information), current medication listing or medication administration record (medical record which would provide the medications ordered and would	F 622		

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F 622	Continued From page 20 identify when last given and next due), and information pertaining to the medical history, including history and physical, recent hospital discharge summary, recent provider notes and orders. The facility policy, Transfer or Discharge, Facility-Initiated, reviewed October of 2022, identified when a resident was transferred from the facility, the receiving facility was to have been provided the following information: documentation of the reason resident needs cannot be met at the facility; contact information of the practitioner responsible for the care of the resident; resident representative contact information; resident status, including baseline information; medications (including when last received); and any other documentation, as applicable to ensure a safe and effective transition of care. In addition, the policy indicated the following information was to be required in the medical record at the facility: the basis for the transfer; notification to legal representative; the date and time of transfer or discharge; a summary of resident's overall medical, physical, and mental condition; and any other information as necessary.	F 622		
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 ensure nail care was provided for 2 of 5 residents (R20 and R26)	F 677	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth	5/16/25

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F 677	Continued From page 21 Findings include: R20's 3/27/25, quarterly Minimum Data Set assessment identified he admitted to the facility in September of 2021, his cognition was severely impaired, and he was dependent on staff for activities of daily living (ADL)'s. R20 had diagnoses of Alzheimer's disease, cerebral palsy, bipolar disorder, and arthritis. Interview on 4/21/25 at 12:35 p.m., with family member (FM)-A reported she has asked the facility staff to clean and trim R20's nails several times. She states "his nails look terrible". Observation on 4/21/25 at 12:36 p.m., of R20's nails on both hands were observed to be untrimmed and extended beyond the tip of his fingers with an unknown black substance observed under each nail from edge to edge. Observation on 4/22/25 at 1:23 p.m., of R20's nails identified they remained the same as above. Observation on 4/23/24 at 2:34 p.m., R20's nails remain overgrown with an unknown black substance under the nail of each finger. Review of R20's undated current care plan identified R20 had a self care deficit requiring assistance with ADL's. Staff were to trim and clean his nails as needed two times weekly on bath day. Review of R20's 4/21/25 Nursing Assistant Bath Worksheet identified R21 had his nails trimmed on 4/21/25. The Worksheet was signed by the charge nurse on duty, however, neither the	F 677	of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does complete nail care as required for residents who are dependent with ADLS Nail care completed for Residents #20 and #26. All residents have the potential to be affected by not receiving nail care. Audit completed on all dependent residents to ensure personal hygiene is being addressed. Policy was reviewed and staff re-educated on ADL documentation and accountability; revised bath sheet to flag missing nail care. DON or Designee will spot-check 5 residents weekly for ADLs x4 weeks, then monthly x2. process results forwarded to the QAA committee for review.	

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F 677	Continued From page 22 nursing assistant nor the nurse were available for interview. R26's 2/18/25 admission Minimum Data Assessment identified her cognition was severely impaired, and she had diagnoses of Alzheimer disease, anxiety, depression, and arthritis. Observation on 4/23/25 at 5:08 p.m., R26's nails on both hands were unkept and overgrown approximately 1/4" beyond the tip of her fingers with sharp, broken, crooked edges. All nail has an unknown black dirt like substance under the tip. Review of R26's 4/19/25 Nursing Assistant Bath Sheet identified the nursing assistant completing the bath did not report she had completed nail care. Interview on 4/23/25 at 4:25 p.m., with licensed practical nurse (LPN)-A reported when a nursing assistant completes a bath they fill out a bath sheet to identify if they completed nail care, vitals, and check skin. The bath sheet is given to the charge nurse and recorded in the record. She identified she does not check the resident to ensure nail cares are completed. Interview on 4/23/25 at 4:26 p.m., with registered nurse (RN)-A identified staff do the bath then fill out a bath sheet and returned it to the charge nurse. She would make a progress note and enter the information provided on the form from the nursing assistant. She reported the licensed nurse does not do anything else unless the nursing assistant reports a new skin concern. She stated "I see nail care as a delegation" She did not see the need to follow up to ensure the tasks were been competed.	F 677		

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GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 677	Continued From page 23 Interview on 4/24/25 at 5:09 p.m., with the facilities RN nursing consultant agreed with the above-mentioned findings and identified she would expect nursing assistants to provide nail care on bath day and would expect the charge nurse to provide oversite by following up with the resident to ensure the task was completed. A policy was requested but was not provided by the end of the survey period.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the hospice plan of care had been integrated with the facility care plan for 1 of 1 resident (R)17 to delineate services provided between the facility and hospice. Findings include: R17's 2/20/25, significant change Minimum Data Set (MDS) identified his cognition was severely	F 684	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does integrate the hospice plan of care with the facility care plan. Resident #17’s care plan was updated to include hospice services.	5/23/25

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F 684	Continued From page 24 impaired, and he was dependent on staff for activities of daily living (ADL)s. R17 had diagnoses of Parkinson's disease, respiratory failure, and diabetes. Review of R17's current care plan identified he was on hospice. The care plan lacked any indication what services hospice was to provide during their visits to the facility. Interview on 4/24/25, at 5:05 p.m., with the nurse consultant identified she agreed with the above findings and would expect nursing staff to ensure the hospice care plan is integrated with the facility care plan. Review of the facilities 2017 Hospice Care policy identified residents receiving hospice services would have coordinated care plans that would include the most recent hospice plan of care and the care and services provided by the facility in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.	F 684	All residents with hospice have the potential to be affected by not integrating the hospice plan of care into the facility care plan. Audit completed of all residents on hospice to ensure integration with facility plans. Staff re-educated on requirements for care plan integration; hospice collaboration policy updated. IDT will review all hospice cases weekly x4 weeks, then monthly x2. process results forwarded to the QAA committee for review.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility	F 689	The plan and/or execution of this plan	5/23/25

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F 689	Continued From page 25 failed to ensure hazardous chemicals were appropriately secured in 1 of 2 unlocked soiled utility rooms located in hall A. This had the potential to affect 16 of 29 residents residing in that hall. Findings include: Observation on 4/21/25 at 1:49 p.m., of the unlocked soiled utility room a bottle of Lysol toilet bowl cleaner was sitting on the counter next to the sink. Some of the cleaner was spilled on the countertop. Interview on 4/21/25 at 1:54 p.m., with the maintenance director confirmed the above findings. He does walk through the building but was unable to recall the last time he had checked the utility rooms. He identified they have a locked closet off the nursing floor that is supposed to be used to store cleaning supplies and other hazardous chemicals. He was not certain who had left the toilet bowl cleaner in the unlocked utility room. Interview on 4/24/25 at 4:58 p.m., with the nurse consultant and administrator identified they would expect staff to ensure all hazardous chemicals are always kept in a locked closet away from the resident areas to ensure there was no risk of injury. Review of the 2017 Hazardous Areas, Devices and Equipment policy identified the facility will be assessed for hazards on an on-going basis. When a hazard is identified the safety committee will give recommendations for measures to ensure that vulnerable residents cannot access hazardous areas in the facility with locks, alarms,	F 689	does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does not leave hazardous chemicals in an unsecured location placing residents at safety risk. No resident harmed. Chemical was removed immediately. All residents have the potential to be affected by hazardous material being unsecured. All storage areas were inspected to ensure no chemicals were unsecured. Policy was reviewed, staff re-educated on safe storage policies, and signs placed on doors to reinforce protocol. Maintenance and nursing supervisors will do weekly rounds to inspect storage areas for 3 months. process results forwarded to the QAA committee for review.	

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F 689	Continued From page 26 supervision, etc.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		5/23/25

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F 756	Continued From page 27 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure pharmacy consultant recommendations were followed up on in a timely manner for 1 of 5 residents (R13) reviewed for pharmacy recommendations.. Findings include: R13's 3/12/25, quarterly Minimum Data Set (MDS) assessment identified his cognition was intact, he had no behaviors, and he was independent with activities of daily living (ADL)'s. R13 had diagnoses of adjustment disorder with depressed mood, hypertension, diabetes, anxiety, orthostatic hypotension, repeated falls, and stroke. Review of R13's pharmacy consultants monthly drug regimen review identified the following: 1. October 2024 pharmacy consultant recommendation: Please assess for continued use of divalproex 250 mg twice daily, CMS guidelines recommend periodic reassessment of psychotropic medication for trial dose reduction consideration in attempts to eventually discontinue unnecessary psychotropics or find lowest effective dose. If current dose is still appropriate for patient, please provide clinical rationale for continuing current dose in the patient medical record. Physician to address ASAP but no later than 60 days. The facility was unable to provide documentation showing the October review had been addressed by the physician or that the physician had been updated.	F 756	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does address or document pharmacy identified medication issues Reviewed pharmacist reports and ensured physician follow-up on flagged issues. All residents have the potential to be affected by not reviewing pharmacy recommendations. Reviewed past 60 days of pharmacist recommendations for missed documentation or action. Reviewed policy, updated communication log between pharmacy and nursing; retrained staff on timely physician notification. Pharmacist reports will be audited monthly for 3 months by DON for compliance. Process results forwarded to the QAA committee for review.	

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F 756	Continued From page 28 2. November 2024 pharmacy consultant recommendation: Please assess for continued use of divalproex 250 mg twice daily, CMS guidelines recommend periodic reassessment of psychotropic medication for trial dose reduction consideration in attempts to eventually discontinue unnecessary psychotropics or find lowest effective dose. If current dose is still appropriate for patient, please provide clinical rationale for continuing current dose in the patient medical record. Physician to address ASAP but no later than 60 days. The November review provided again had no indication that the physician had been updated. 3. January 2025 pharmacy consultant recommendation: Prednisone oral tablet 20 mg give 40 mg by mouth in the morning for preoperative dose related to irritable bowel syndrome, unspecified for three days. Prednisone oral tablet 5 mg Give 20 mg by mouth in the morning for preoperative exam prep for three days Prednisone oral tablet 5 mg, Give 20 mg by mouth in the morning for three days. Please verify if patient should be taking 20 mg, 40 mg, or 60 mg of prednisone for pre-op. Also, should he take 5 mg dose as well those days? The January pharmacy consultant recommendations did not include a response or signature from the physician. 4. February 2025 pharmacy consultant recommendation was to add a diagnosis for the use of: prednisone oral tablet 5 mg (prednisone) 5 mg by mouth in the morning. Pyridostigmine bromide oral tablet 60 mg (pyridostigmine Bromide) Give 1 tablet by mouth three times of day. The facility was unable to provide any	F 756		

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F 756	Continued From page 29 documentation to show they had updated the physician. Review of the provided copy of the pharmacy review did not include a physician signature. Interview on 4/24/25 at 9:03 a.m., with the director of nursing identified she agreed with the above findings. She reported she does not have a good process in place and would like some help with getting these pharmacy consultant medication reviews organized. Interview on 4/24/25 at 5:00 p.m., with the nurse consultant identified she agreed with the above findings, she reported she has also looked for the documentation showing they had updated the physician and she was also unable to locate it in the medical record. It is her expectation the facility follow-up with the physician once they receive the monthly pharmacy consultant reviews, she would expect this to be completed timely and the facility should have a process to maintain this documentation in an organized fashion. A policy was requested but nothing was provided by the end of the survey period.	F 756		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications	F 759	The plan and/or execution of this plan does not constitute admission or	5/23/25

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F 759	Continued From page 30 were administered in accordance with physicians orders and manufacturers guidelines for 2 of 7 (R24 and R30) residents observed to receive medications. A total of seven (7) errors out of 26 errors were identified, resulting in a 26.9% (percent) facility error rate. Findings include: On 4/22/25 at 3:56 p.m., licensed practical nurse (LPN-A) was observed to prepare medications at a mobile medication cart in the hallway of the unit. R24 was in the hallway and approached the medication cart for medication administration. LPN-A proceeded to set up medications, including topical medication Voltaren External Gel 1 % (Diclofenac Sodium). The label for this prescription cream directed staff to apply two gm (grams). LPN-A stated she did not have the dispensing film to measure out the two grams as ordered, however, R24 only wished to receive a pea sized amount. LPN-A was unsure how much this was comparative to the two grams amount ordered. LPN-A stated the order on the med sheet, as well as on the label was to be administered, however, R24 preferred only a smaller amount. Immediately following observation of administration of medications, a review was completed of R24's electronic medical record, and Medication Administration Record. A review of the electronic Medication Administration Record indicated the following order: Voltaren External Gel 1 % Diclofenac Sodium (Topical); Apply to knees topically three times a day for knee pain. Apply 2 grams to affected joints. The start date for this order was 10/11/24. Upon review of the Voltaren gel information on	F 759	agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does ensure residents are free of significant medication errors. Medication error was immediately addressed with physician notification and monitoring of the resident. Staff involved received re-education and a competency evaluation was conducted. All residents have the potential to be affected if medication administration processes are not followed properly. A review of all current residents' orders were completed. To ensure protection of residents in similar situations a nurse will put in the official order and a second nurse will verify the orders for accuracy. Audits on medication administration will occur randomly. Policies were reviewed and staff were re-educated on the five rights of medication administration to include appropriate crushing of medications. The DON or designee will complete random medication administration observation/audits weekly x4 weeks, then monthly x2 months and, results will be	

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F 759	Continued From page 31 https://www.drugs.com/dosage/voltaren-gel, it was identified the 2-gram line is 2.25 inches long. R30's Order Summary Report, dated 4/24/25, identified R30's current physician-ordered medications and treatments. These orders included the orders for Aspirin Delayed Release 325 mg by mouth in the morning for pain with order date of 1/15/25. The orders also included Colace (Docusate sodium) 100 mg by mouth twice a day for stool softener, effective 1/15/25. R30 had orders also noted for Furosemide 20 mg by mouth every morning for tachy-brady syndrome and edema (swelling) effective 3/12/25. R30 had orders in place for Gabapentin 100 mg capsule ordered twice daily by mouth for pain effective 1/22/25. Additional orders were in place for Metoprolol 25 mg twice daily by for essential hypertension, effective 1/21/25. The orders directed staff to give with food. R30 also had orders in place, effective 1/22/25, for Tylenol (acetaminophen) 500 mg two tablets three times a day for pain management. The orders also included Vitamin D3/cholecalciferol (2000 IU)/50 mcg (a unit of measurement) one tablet daily for Vitamin D deficiency, effective 3/6/25. The orders also identified orders for Potassium Chloride Crystals ER (Extended Release) (K-Cl ER) 20 mEq by mouth in the morning for mineral balance. R30's EMAR, printed 4/24/25, identified the above listed medications. The instructions outlined on the EMAR lacked any additional instructions for administration of medications. The EMAR lacked direction to the staff to crush medications and mix with applesauce prior to administration.	F 759	forwarded to the QAA committee for review.	

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F 759	Continued From page 32 On 4/23/25, at 7:29 a.m. TMA-B prepared R30's medication at a mobile cart in the hallway near the nurses station. TMA-B proceeded to set up medications for R30 upon review of the EMAR. TMA-B informed surveyor medications were crushed for R30. The following medications were removed from the med cart, compared to the EMAR for accuracy, and set up by TMA-B: Aspirin (ASA) 325 mg one tablet daily by mouth; Colace (Docusate Sodium) 100 mg one tablet twice daily by mouth; Furosemide 20 mg one tablet daily in the morning by mouth; Metoprolol 25 mg one tablet twice daily by mouth; Acetaminophen 500 mg two tablets three times a day; and Vitamin D3/cholecalciferol (2000 IU)50 mcg one. Upon preparation of the Gabapentin 100 mg one capsule twice daily by mouth, the capsule was opened and contents placed into applesauce. TMA-B prepared the K-Cl ER 20 mEq one tablet every morning by mixing this with a small amount of water to prepare a slurry (dissolving the medication in water to give in a suspension). Upon setting up all medications as outlined, with the exception of the Gabapentin and K-Cl ER, the medications were subsequently crushed and placed into applesauce. The medications were then administered to R30. On 4/23/25, at 12:50 p.m. TMA-B was interviewed in follow up regarding the process to determine whether or not to crush meds. TMA-B stated she knew orders to crush medications came from therapy (speech therapy). TMA-B stated the staff would perform a trial to see what worked best for the resident, then a crush order would be obtained if indicated. TMA-B stated she was unsure where the order was found on the electronic medical records (EMR). TMA-B stated	F 759		

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F 759	Continued From page 33 this information was relayed to the oncoming staff at shift reports. The information was also displayed on the resident "banner" within the EMR, and was generally noted in red. Upon review of the banner for R30, TMA-B stated the order crush meds was not observed in the "banner". On 4/23/25, at 1:50 p.m. inquired of TMA-B if there have been any problems to date with administration of crushed meds for R30. TMA-B stated R30 had no problems with crushed meds. On 4/24/25, at 3:45 p.m. the assistant director of nursing (ADON) stated the provider must provide the order allowing crushed meds before this would be initiated. The ADON went on to say medications would then be crushed unless it was contraindicated to do so. The ADON stated this order would be placed on the order sheet, and would be found under "Other orders". If the orders were entered correctly, it would also be displayed on the resident banner in the EMR. A review of the R30's EMR lacked indication of orders by the provider, as well as information in the banner regarding authorization to crush medications. During interview on 4/24/25, at 3:51 p.m., the director of nursing (DON) stated orders must have been obtained from the provider before medications were given crushed. The assistant director of nursing (ADON) was in the office during this discussion, and upon review of the concerns regarding crushing of meds for R30, verified there were no orders in place in the EMR. In regards to R24, DON stated medications were to be given as prescribed. DON stated if a lesser dose was requested, as in the Diclofenac amount for R24, the provider was to be contacted in	F 759		

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F 759	Continued From page 34 update and an alternate order was to be obtained. On 4/23/25, at 4:17 p.m. the consulting pharmacist (CP) was provided an overview of the medications being given without a provider order to crush medications. CP stated a provider order was needed before medications were crushed and given to the resident, and medications were not to be given crushed without first consulting the provider. CP stated prior to authorization to crush the medication, the provider reviewed the residents medication and a determination would need to be made as to if the medications were acceptable to crush. If the provider deemed it was not appropriate to crush medications, an alternate method of administration/or alternate medication with a different delivery source would need to be considered. A review was completed with the medications which were given crushed. CP stated upon review of the medications, CP stated ASA was a medication which was not to be crushed. When asked if this was considered a significant medication error, CP stated she did not wish to give things a label. A facility policy, noted to have been revised April 2018, indicated "The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify the appropriate indications and procedures for crushing medications." The policy identified the order to crush medications must come from the physician. The policy identified the MAR or other documentation must indicate why it was necessary to crush the medication. A facility policy, titled Administering Medications, last revised December 2012. identified: If a dosage is believed to be inappropriate or	F 759		

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F 759	Continued From page 35 excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/23/25

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F 761	Continued From page 36 Based on observation, interview, and document review, the facility failed to ensure prescribed medications were labeled with current physician-ordered administration instructions to reduce the risk of administration error for 1 of 6 residents (R24) observed to receive medication during the survey. Findings include: R24's quarterly Minimum Data Set (MDS), dated 12/3/24, identified R24 had intact cognition with several medical diagnoses which included a medically complex condition, restless leg syndrome, muscle weakness, and difficulty walking. On 4/22/25 at 3:56 p.m., licensed practical nurse (LPN-A) was observed to prepare medications at a mobile medication cart in the hallway of the unit. R24 was in the hallway and approached the medication cart for medication administration. LPN-A proceeded to set up medications, including obtaining the med card for Tramadol from the locked box. LPN-A stated R24 received Tramadol HCl 50 mg one tablet every eight (8) hours, and this was given on a routine basis.. A review of the label indicated the dosing for the medication was for every eight hours, as needed, and did not identify that it was scheduled. LPN-A reviewed electronic medical record with surveyor, and orders reflected the order was for three times a day, and was not listed as a medication to be given as needed. LPN-A stated the label on the prescriptions were to accurately reflect the orders for the medications by the provider and indicated she was going to send a request to pharmacy for a label change to accurately reflect orders. A review of the electronic Medication Administration	F 761	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does ensure medications are stored securely and appropriately labeled in medication carts. Improperly stored medication was immediately secured and relabeled appropriately. All residents have the potential to be affected if medications are not securely stored or medications are inappropriately labeled. Audit completed on all medication carts and storage areas to ensure compliance. Reviewed policy, staff re-educated on proper labeling and storage procedures. Pharmacy consultant involved in training. DON or designee will complete weekly random audits of medication carts for 4 weeks, then monthly for 2 months. Process results forwarded to the QAA committee for review.	

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F 761	Continued From page 37 Record indicated the following orders: Tramadol HCl 50 mg one tablet by mouth three times daily. The start date of the prescription was on 8/31/24. A review of the R24's orders printed 4/24/25, identified R24 was to receive Tramadol HCl one tablet by mouth three times a day for pain effective 8/30/24, with a start date of 8/31/24. On 4/24/25 at 3:51 p.m., the director of nursing was interviewed regarding medication labeling and label checks during medication administration. DON stated the medication labels were to reflect current order. DON stated if a discrepancy was noted, the staff were to verify the correct dose ordered and request a label correction as needed. DON stated medications are to be given as prescribed. A facility policy, titled Administering Medications, last revised December 2012. identified: Medications shall be administered in a safe and timely manner, and as prescribed. The policy directs staff "must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		5/23/25

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F 812	Continued From page 38 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure cleanliness and monitoring of temps, and undated foods in 1 of 2 refrigerators in dining rooms, and 5 of 5 residents'(R7, R11, R13, R16, and R29) personal refrigerators located in resident rooms. Findings include: R16's 3/3/22, quarterly Minimum Data Set (MDS) assessment identified her cognition was intact, she had verbal behaviors towards others two-three days a week, and she was independent with meals and hygiene but required assistance with set up for dressing. R16 had diagnoses of morbid obesity, vascular disease, chronic kidney disease, adjustment disorder, and history of stroke. Observation on 4/22/25 at 5:03 p.m., of R16's room identified she had a small dorm style refrigerator. Inside the refrigerator she had 7 plastic containers with left over foods in them. The containers were not labeled and did not have dates on them. One container had tuna, one container had chicken, and one container had rice. The refrigerator also had condiments and	F 812	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does store food under sanitary conditions, monitors refrigerator temperatures, and dates food that is being stored. All expired food items were immediately discarded, and the refrigerators were cleaned and sanitized. Temperature logs were placed on the dining room, memory care, and 5 resident refrigerators. All residents have the potential to be affected by improper food storage or use of expired items. Policy was reviewed and staff were re-educated on the food storage policy.	

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F 812	Continued From page 39 cans of pop. The refrigerator did not have a log to monitor temperature and no thermometer was observed. Interview on 4/23/25 at 7:52 a.m., with the kitchen manager identified nursing is responsible for maintaining personal refrigerators located in resident rooms. Interview on 4/23/25 at 9:33 a.m., with the director of nursing (DON) identified she was not aware that nursing was supposed to monitor the refrigerators in resident rooms for temperature, outdated food, and cleaning. Nursing does monitor the medication room and the dining room refrigerator. She identified she thought it was kitchens responsibility but had just asked them and they said it was nursing's responsibility. She said they had five residents in the facility that had a small refrigerator in their room but she did not know if they were being monitored. Observation on 4/23/25 at 10:13 a.m., of the refrigerators located in resident rooms identified the following: 1.) R29's refrigerator did not have anything in it, there was a thermometer located inside fridge but did not have a log to monitor temperatures. 2.) R11's refrigerator contained beef sticks, and an open container of cheese did. There was a thermometer inside the fridge, but no log was observed in the area for monitoring the temperature. 3.) R13's refrigerator was dirty; it had a glass of juice that was not covered and not dated and a banana that had turned completely black. There was a thermometer, but no log observed in the area for monitoring. 4.) R7's refrigerator had cookies and cans of pop	F 812	Dietary staff will record temperatures and clean the dining room refrigerator, staff working in memory care will record temperatures and clean the memory care refrigerator, housekeeping staff will record temperatures and clean the 5 resident refrigerators. Administrator or Designee will audit the temperature logs, cleanliness of refrigerators, and check for undated and/or expired food weekly for 1 month and monthly moving forward.	

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F 812	Continued From page 40 in it. There was no thermometer in the fridge and no log observed in the area for monitoring. Observation on 4/23/25 at 10:00 a.m., of the refrigerator located in the memory care resident dining area, had a temp log located on the refrigerator door. The log had a column for daily temperatures in the a.m. and p.m. The April 2025 log had entries indicating the refrigerator temperature from 4/1/25 through 4/23/25 on the following dates and times, 4/1/25 a.m., 4/7/25 p.m., 4/8/25 p.m., 4/13/25 p.m., 4/17/25 p.m. The other 25 days had no documented monitoring of the refrigerator temperatures. The outside of the door had a functioning ice dispenser, that had a black and yellow substance on the lever and the tray beneath. The inside of the freezer was observed to have hair sticking to the shelves and the inside of the door, food crumbs, and a brown sticky substance on the shelves, and a piece of Styrofoam laying in a bin at the bottom of the freezer. TMA-B was observed to use the ice dispenser to fill a glass with ice and water and then served it to a resident seated at the table. Interviewed on 4/23/25 at 10:05 a.m., with TMA-B identified she was not sure who was responsible to log the temperatures, but she thought it was the over-night staff. She reported they do not have a cleaning schedule for the refrigerator but they "try to clean it as they go". She looked at the ice dispenser and inside the freezer and agreed the log had not been completed and the freezer and ice dispenser was dirty. Review of the facility provided Refrigerators and Freezers policy dated December 2014, identified the facility would ensure safe refrigerator and freezer maintenance, temperatures, and	F 812		

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F 812	Continued From page 41 sanitation, and will observe food expiration guidelines. The facility would use monthly tracking sheets for all refrigerators and freezers and the logs would be posted. The food service supervisor or designated employees will check and record refrigerator and freezer temperatures daily withy first opening and at closing in the evening. All food shall be appropriately dated to ensure proper rotation by expiration dates and all refrigerators and freezers will be kept clean and free of debris on a scheduled basis. The policy made no mention of personal refrigerators located in resident rooms.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865		5/23/25

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F 865	Continued From page 42 promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership	F 865		

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F 865	Continued From page 43 (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		

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F 865	Continued From page 44 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a Quality Assurance and Performance Improvement (QAPI) plan that identified necessary policies and procedures describing how the facility will identify and correct quality deficiencies. This had the potential to affect all 29 residents residing in the facility. Findings include: When interviewed on 4/23/25 at 1:29 p.m. the administrator indicated there was no formalized QAPI plan in place to track and measure performance, no goals established to measure performance, and no development or implementation of corrective action or performance improvement activities. The administrator stated although there were attendance rosters available for quarterly QAPI meetings from the past year, the facility lacked any documentation to reflect the QAPI process. The administrator stated awareness of the need for and importance of the QAPI process, however, was new to the facility and this had not yet been implemented. During follow up interview on 4/24/25 at 4:54 p.m., the administrator stated she had again reviewed all documentation in place for QAPI and had not located any information for the past QAPI program. The administrator reported information was present for 2023, however, there was not documentation for 2024 to present. During an interview on 4/24/25 at 3:51 p.m., the director of nursing (DON) stated the facility held	F 865	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does develop comprehensive QAPI plans based on facility specific data and outcomes. No direct resident impact; QAPI plan is systemic. All residents have the potential to be affected due to ineffective quality oversight. Policy was reviewed, QAPI program updated with SMART goals and measurable objectives. Department heads involved in revision. QAPI Committee will meet monthly to review implementation, process results forwarded to the QAA committee for review.	

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F 865	Continued From page 45 quality assurance meetings quarterly, which she had attended. The DON stated during these meetings, she presented updates regarding infection control, and current status within the facility. The DON lacked any documentation related to QAPI presentation of information, or of any previous, or current QAPI programs in place. The facility policy and procedure, titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan, updated on 1/2/25, was provided for review. The policy identified facility specific QAPI goals were to implement the QAPI process successfully as evidenced by the formulation of effective Performance Improvement Plans. In addition, the policy identified specific QAPI goals were to be found within the QAPI committee documentation and Performance Improvement Committee(s) documentation.	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and	F 867		5/23/25

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F 867	Continued From page 46 opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that	F 867		

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F 867	Continued From page 47 will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867		

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F 867	Continued From page 48 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the quality assurance (QA) team developed, and revised, a quality improvement program to correct infection control concerns identified through tracking and trending and the infection control process as presented by the director of nursing (DON) during routine QAPI meetings. This had the potential to affect all 28 residents residing in the facility. Findings include: On 4/23/25, at 8:28 a.m., the administrator provided information for review related to the Quality Insurance Performance Improvement (QAPI) meeting attendance rosters, and meeting minutes for the current QAPI program. A review of the attendance roster and meeting minutes lacked indication as to what the overall program focused on, as well as what the Performance Improvement Plan (PIP) focus was. The	F 867	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does act on data gathered during audits to implement improvements or prevent reoccurrence. No specific resident harmed. Quality concerns reviewed and prioritized for corrective plans. All residents have the potential to be affected by lack of responsive action to quality issues. Policy was reviewed, audit tool updated to	

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F 867	Continued From page 49 information following the attendance roster of 1/17/24 included hand written notes, however, these notes provided no context as to what the QAPI program was focusing on, benchmarks and goals, or information regarding the current PIP programs. The minutes did reference infection control, and identified no patterns of infection. The meeting minutes referenced 22 staff days lost [related to illness], and also identified "11 Covid in December". A review of the remainder of the meeting attendance sheets lacked further agendas, meeting minutes, or documentation until 3/19/25. Upon review of the final document provided by the facility, the meeting minutes identified the PIP review as "Anti-psychotic will begin 3/20/25 in weekly meeting." Upon further review, it was noted under the area titled Infection Control, there was "no Covid, four infections, no trends". The document identified the following under the area titled "action plan/follow up" : auditing TB (tuberculosis), PPE (personal protective equipment), Peri-Care audits performed. During follow up interview on 4/23/25 at 4:54 p.m., the administrator stated she was unable to locate any program specific information regarding the QAPI program, or PIP initiatives, prior to her arrival as the administrator approximately one month ago. The administrator stated at this time, the facility is in the beginning stages of formalizing the QAPI program, and development of the PIP. The administrator stated they were planning to utilize the current survey results to identify focus areas for the PIP. The administrator stated upon receipt of the survey results, the QAPI team would review, and further their process at this time.	F 867	track issues to resolution. Follow-through checklist implemented. Administrator will oversee the QAPI program and process results forwarded to the QAA committee for review.	

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F 867	Continued From page 50 The facility policy and procedure, titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan, updated on 1/2/25, was provided for review. The purpose statement indicated the purpose of QAPI was to develop a culture of proactive leadership and identify plans for improvement leading to systematic changes. The policy identified under guiding principles the following; QAPI program will be ongoing and comprehensive, dealing with the full range of services that we provide, including all departments; and, the organization expects areas for improvement to be identified.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		5/23/25

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F 880	Continued From page 51 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 52 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a current, ongoing system of infection control (IC) surveillance to identify potential outbreaks of infectious disease, analyze data, and track infections through to resolution or identify the need to alter treatment. The facility also failed to ensure employee illnesses were tracked to identify when staff last worked and the criteria for when they would be allowed to return to work. The facility also failed to ensure staff appropriately wore a gown (personal protective equipment (PPE)) and/or bagged soiled linen during transport. This had the potential to affect all 29 residents in the facility. In addition, the facility failed to appropriately disinfect 1 of 1 resident's (R7) glucometer prior to returning it to the medication cart, Findings include: RESIDENT INFECTION SURVEILLANCE Review of the infection surveillance logs from January 2025 through March 2025 identified the columns for name, room #, infection date, site of infection, culture taken, causative agent, antibiotic treatment, isolation precautions and center acquired (obtained while in the facility). In January 2025, three residents (R100, R101, and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection	F 880	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does adhere to required infection control practices The glucometer used for Resident #7 was immediately removed from use and properly disinfected according to manufacturer and facility policy. All Residents have the potential to be affected by improper infection control practices. All medication carts and shared resident care equipment were inspected and disinfected as needed. A facility-wide audit of glucometer disinfection practices, PPE use, linen handling, and infection surveillance records was conducted to determine if other residents were potentially affected. Staff illness logs were reviewed to identify any untracked or unresolved illnesses with resident exposure potential.	

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F 880	Continued From page 53 (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. Isolation was marked "yes". R100 second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no date identified when R100 was put on precautions, what type of precautions were implemented, what their symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R101 had a skin infection dated 1/31/25. No culture was marked as taken. Zesorb antifungal medication 2% powder was ordered for 14 days, twice daily. It is unknown where the infection was located, or if it resolved after therapy. 3) R18 was noted to have pneumonia. A culture was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, four residents (R30, R18, R23, and R13) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was	F 880	The Infection Preventionist (IP) reviewed the facility's Infection Surveillance Policy and Procedure to: Ensure specific guidance on outbreak identification, trend analysis, and action thresholds. Require documentation of follow-through on all identified infections until resolution. Staff were re-educated on: Proper PPE use, including gown use during contact precautions. Proper handling and bagging of soiled linens during transport. Cleaning and disinfecting glucometers and other shared medical equipment after each use. Reporting and tracking staff illness and return-to-work criteria. Hand Hygiene Procedures Signage and reminders were placed in medication and utility rooms regarding infection control protocol The IP or designee will: Conduct random weekly audits of glucometer disinfection and PPE use for 4 weeks, then monthly for 3 months.	

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F 880	Continued From page 54 no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation as part of infection control surveillance to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. 4) R13 was noted to have an infection to a neck surgical incision dated 2/29/25. R13 was given an IV antibiotic. No isolation precautions were noted. R13's progress notes identified R13 had cervical (neck) surgery on 2/6/25 and began showing signs of potential infection on 2/17/25, with surgical site swelling and a non-productive cough was noted. On 2/19/25, R13 had a temperature of 100.4 and complained of vomiting. R13 was sent to the physician's office, who then admitted him to the hospital for treatment. R13 returned to the facility again on 2/24/25 and had a peripherally inserted central catheter (PICC) line (catheter placed into a vein to administer medication directly into the bloodstream for serious	F 880	Audit infection tracking logs weekly for 3 months to verify that all infections are documented, monitored through resolution, and analyzed for trends. Audit linen handling practices weekly for 4 weeks. Monitor staff illness logs weekly to ensure adherence to return-to-work criteria. Audit results will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting and corrective actions implemented as needed.	

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F 880	Continued From page 55 infections). There was no indication R13 was placed on enhanced barrier precautions (EBP) upon his return. In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25. The site of the infection was "old peg tube site/skin". No culture was taken. R15 was placed on augmentin (antibiotic). No isolation precautions were noted as having been placed. There was no indication R15 was on enhanced barrier precautions (EBP) prior to the infection to reduce the risk of infection before it had occurred. There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, R16 was placed on augmentin. No isolation precautions were implemented. There was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. Review of the National Library of Medicine October- December 2013 article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC3836000/ identified that bacteria was known to be emerging as a multi- resistant pathogen (MDRO). There was no indication R5 was placed on EBP or if the infection preventionist had provided appropriate oversight to ensure the potential to spread the infection was limited or if R5's strain of bacteria was resistant to the antibiotic ordered or if the antibiotic was appropriate. 4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No isolation was noted to be implemented and no culture was	F 880		

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F 880	Continued From page 56 noted. There was no indication during any of the above-mentioned surveillance as to whether the infection date was the date when the resident had been diagnosed or if it indicated the onset of symptoms. There was no mention what symptoms each resident had, when transmission based precautions (TBP) were placed or what type of precautions were implemented. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of resistant strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. The information obtained from	F 880		

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F 880	Continued From page 57 surveillance was to be compared with data from other facilities with use of acknowledged standards and used to assess effectiveness of IC practices. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication. EMPLOYEE SURVEILLANCE Review of the employee surveillance from January 2025 through March 2025 identified the social services designee (SSD) called in sick on 2/17/25 and was noted to have a a diagnosis of Strep (bacterial throat infection) with a fever of 102 degrees Fahrenheit (F) . There was no last day of work noted, if and/when the SSD returned to work, or if she received any antibiotic therapy. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. The SSD's time card for 2/17/25 identified she had worked 5 hours on 2/17/25, and returned for	F 880		

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F 880	Continued From page 58 a full day (8 hours) on 2/18/25. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to have established policies and procedures for infection control among employees where staff should report their infections or avoid the facility. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. PPE/SOILED LINEN Observation on 4/21/25 at 4:45 p.m., of medication aid (TMA)-B walking down the hallway carrying a ball of rolled up sheets, a reusable pad (used as an additional barrier on residents' beds), and a pair of pants. The clothing and linens were touching her clothing, she dropped the pad on the floor and bent over and picked it back up and continued down the hall to the soiled utility room. Interview on 4/21/25 at 5:20 p.m., with TMA-B confirmed she was carrying the linens and clothing down the hall, the items were touching her clothing, and she had dropped some of them on the floor. She confirmed they were not bagged, and she reported they were soiled with urine. She identified she was aware she was supposed to bag soiled linens before taking them out of the room due to risk for cross	F 880		

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F 880	Continued From page 59 contamination. She identified she normally bags soiled linens but was in a hurry. Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was responsible for so many other tasks and noted she did not have enough time to complete her duties. "I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working.	F 880		

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F 880	Continued From page 60 Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to educate staff and ensure they adhered to proper IC techniques and procedures. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control.	F 880		

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	245360	A. BUILDING _____ B. WING _____	C 04/24/2025

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F 880	Continued From page 61 Glucometer cleaning R7's significant change Minimum Data Set assessment of 1/28/25, indicated R7 had moderate cognitive impairment. R7 was identified as receiving help with activities of daily living. R7's medical diagnoses included diabetes (a group of diseases that affect how the body uses blood sugar (glucose), as well as endocrine (the system which released hormones into your blood while continuously monitoring the levels), nutritional, and metabolic diseases (any of the diseases or disorders that disrupt normal metabolism, the process of converting food to energy on a cellular level). On 4/22/25 at 4:30 p.m., licensed practical nurse (LPN)-A was observed during routine medication pass. At this time, R7 was due for blood sugar monitoring (checking the level of blood sugar in the blood to help determine if medication or additional interventions are needed). LPN-A performed hand hygiene and set up equipment to complete blood sugar check, using R7's monitor. LPN-A brought gloves to room along with equipment, and donned gloves before starting the procedure. R7's finger was cleansed with an alcohol prep, blood was drawn with the use of a disposable lancet (needle used for blood sugar checks), and blood sugar was checked with glucometer (a machine used to check blood sugars). LPN-A gathered supplies and exited room. The lancet was disposed of appropriately, machine was placed on cart, gloves removed and hand hygiene performed. LPN-A then applied gloves and wiped the machine with an alcohol wipe to clean/sanitize the machine. LPN-A stated this was the process she was trained in when she started at the facility. LPN-A proceeded to return	F 880		

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F 880	Continued From page 62 the machine to the med cart in the area designated for R7's machine. LPN-A then removed gloves and performed hand hygiene before proceeding to the next task. On 4/22/25, at 4:35 p.m., an interview was held with the director of nursing (DON) to inquire of the process for sanitizing glucometers following performing a blood glucose test. DON stated the glucometer should be cleaned with the use of a disinfectant wipes, wrapping the glucometer in the wipe and allowing to dry to complete the sanitation process. Nurse Consultant (NC) was also present at this time, and verified EPA (Environmental Protection Agency) approved wipes should be used for sanitation. The facility policy, Blood Glucose Monitoring Policy and Protocol, undated, identified "All glucometers will be cleaned per manufacturer recommendations prior to performing bedside test. The policy then later identified "The glucometer will be cleaned prior to each use and after after each use per manufacturer recommendation." The policy lacked indication as to what product was to be used with cleaning, aside from identifying per manufacturers recommendations. The manufacturer's policy for the glucometer, with the recommendations for cleaning, was requested and not received.	F 880		
F 881 SS=E	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:	F 881		5/23/25

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F 881	Continued From page 63 §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 have an antibiotic stewardship program to identify appropriate antibiotic use for 10 of 10 sampled residents (R1, R100, R18, R30, R18, R23, R15, R16, R5, and R101). Findings include: Review of the infection surveillance logs from January 2025 through March 2025 identified: In January 2025, two residents (R100 and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. R100's second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was also prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no information to identify what R100's symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R18 was noted to have pneumonia. A culture	F 881	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does maintain a functional antibiotic stewardship program that tracks usage trends. A. A review of all current residents with active infections was conducted to ensure appropriate documentation and treatment review. The physician and pharmacy reviewed residents for prolonged antibiotic antibiotics. B. All residents have the potential to be affected by improper antibiotic stewardship program. a. The infection surveillance logs were reviewed and updated to include all infections regardless of treatment status to ensure comprehensive data collection. b. The facility will follow McGeer Criteria for infection surveillance and diagnosis. c. An antibiotic time out will be conducted on all antibiotics ordered 48-72 hours after initiation to reassess the need, spectrum, and duration of therapy.	

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F 881	Continued From page 64 was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, three residents (R30, R18, and R23) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25.	F 881	C. Policy was reviewed and all staff have been educated on antibiotic stewardship, McGeer criteria and the importance of antibiotic timeouts. D. Surveillance logs, adherence to McGeer criteria and antibiotic timeouts will be audited by the DON or Designee weekly x4, then monthly x2. Process results forwarded to QAA committee for review.	

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F 881	Continued From page 65 The site of the infection was "old peg tube site/skin". No culture was taken. R15 was placed on augmentin (antibiotic). There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, and R16 was placed on augmentin. There was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. 4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No culture was noted. There was no mention what symptoms each resident had. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. R1's 3/4/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was moderately impaired and she was dependent on staff for activities of daily living (ADL)'s. R1 had diagnoses of dementia, heart failure, diabetes, multiple sclerosis, anxiety, and depression, and had been taking an antibiotic. R1's 4/9/25, physician order with lab results that identified her urine was positive for Aerococcus (a bacterium associated with urinary tract infections). The lab result included an order for R1 to start taking Macrobid 100 milligrams (MG) twice a day for 7 days. The order noted a	F 881		

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F 881	Continued From page 66 susceptibility lab (test to identify what antibiotic the bacterium is susceptible to) was not completed. R1's April 2025, medication administration record identified she was administered 14 doses of macrobid 100 mg by mouth from 4/11/25 through 4/18/25. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control. Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented	F 881		

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F 881	Continued From page 67 infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was responsible for so many other tasks and noted she did not have enough time to complete her duties. "I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working. Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. Review of the undated, Antibiotic Stewardship policy identified the facility would monitor the use of antibiotics by residents, staff would receive education that will include inappropriate use of antibiotics and how they affect residents. The policy did not identify a process of how the infection preventionist should monitor and communicate with the prescribing provider of the	F 881		

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F 881	Continued From page 68 effectiveness or appropriateness of the antibiotic prescribed. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of resistant strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)	F 882		5/23/25

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F 882	Continued From page 69 (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the infection preventionist had the appropriate time allotted to have oversight of the facility infection control program and was deemed competent in providing that oversight. This had the potential to affect all 29 residents. Findings include: RESIDENT INFECTION SURVEILLANCE Review of the infection surveillance logs from January 2025 through March 2025 identified the columns for name, room #, infection date, site of infection, culture taken, causative agent, antibiotic treatment, isolation precautions and center acquired (obtained while in the facility). In January 2025, three residents (R100, R101, and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate	F 882	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. Glen Oaks does designate an Infection Preventionist to actively monitor and oversee all required domains. A. A comprehensive review of all current residents with active infections was conducted to ensure appropriate documentation of infection onset and treatment and verification of treatment appropriateness, culture results was completed. The Infection Preventionist has been	

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F 882	Continued From page 70 infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. Isolation was marked "yes". R100 second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no date identified when R100 was put on precautions, what type of precautions were implemented, what their symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R101 had a skin infection dated 1/31/25. No culture was marked as taken. Zesorb antifungal medication 2% powder was ordered for 14 days, twice daily. It is unknown where the infection was located, or if it resolved after therapy. 3) R18 was noted to have pneumonia. A culture was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, four residents (R30, R18, R23, and R13) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra	F 882	allocated dedicated time specifically for infection prevention duties to meet regulatory compliance with the facility's needs. B. All residents have the potential to be affected by inadequate infection surveillance. a. The infection preventionist will conduct active surveillance of all resident and staff infections regardless of antibiotic treatment was initiated and oversee staff illness and return to work procedure to prevent communicable disease spread. b. McGeer Criteria will be implemented and used consistently by prescribers to guide infection diagnosis and antibiotic use. c. Antibiotic Time Outs will be completed 48-72 hours after antibiotic initiation to assess continued need and appropriateness. d. The IP will conduct monthly infection control data analysis and present findings and trends to QAA committee. C. Policy was reviewed and the infection preventionist and all staff were educated on infection preventionist responsibilities. D. Time spent on infection preventionist duties, surveillance logs, adherence to McGeer criteria and antibiotic timeouts and data analysis will be audited weekly x4, then monthly x2. Process results forwarded to QAA committee for review.	

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F 882	Continued From page 71 DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation as part of infection control surveillance to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. 4) R13 was noted to have an infection to a neck surgical incision dated 2/29/25. R13 was given an IV antibiotic. No isolation precautions were noted. R13's progress notes identified R13 had cervical (neck) surgery on 2/6/25 and began showing signs of potential infection on 2/17/25, with surgical site swelling and a non-productive cough was noted. On 2/19/25, R13 had a temperature of 100.4 and complained of vomiting. R13 was sent to the physician's office, who then admitted him to the hospital for treatment. R13 returned to the facility again on 2/24/25 and had a peripherally inserted central catheter (PICC) line (catheter placed into a vein to administer medication	F 882		

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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 882	Continued From page 72 directly into the bloodstream for serious infections). There was no indication R13 was placed on enhanced barrier precautions (EBP) upon his return. In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25. The site of the infection was "old peg tube site/skin". No culture was taken. R15 was placed on augmentin (antibiotic). No isolation precautions were noted as having been placed. There was no indication R15 was on enhanced barrier precautions (EBP) prior to the infection to reduce the risk of infection before it had occurred. There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, R16 was placed on augmentin. No isolation precautions were implemented. There was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. Review of the National Library of Medicine October- December 2013 article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC3836000/ identified that bacteria was known to be emerging as a multi- resistant pathogen (MDRO). There was no indication R5 was placed on EBP or if the infection preventionist had provided appropriate oversight to ensure the potential to spread the infection was limited or if R5's strain of bacteria was resistant to the antibiotic ordered or if the antibiotic was appropriate. 4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No isolation	F 882		

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F 882	Continued From page 73 was noted to be implemented and no culture was noted. There was no indication during any of the above-mentioned surveillance as to whether the infection date was the date when the resident had been diagnosed or if it indicated the onset of symptoms. There was no mention what symptoms each resident had, when transmission based precautions (TBP) were placed or what type of precautions were implemented. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. R1's 3/4/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was moderately impaired and she was dependent on staff for activities of daily living (ADL)'s. R1 had diagnoses of dementia, heart failure, diabetes, multiple sclerosis, anxiety, and depression, and had been taking an antibiotic. R1's 4/9/25, physician order with lab results that identified her urine was positive for Aerococcus (a bacterium associated with urinary tract infections). The lab result included an order for R1 to start taking Macrobid 100 milligrams (MG) twice a day for 7 days. The order noted a susceptibility lab (test to identify what antibiotic the bacterium is susceptible to) was not completed. R1's April 2025, medication administration record identified she was administered 14 doses of macrobid 100 mg by mouth from 4/11/25 through	F 882		

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F 882	Continued From page 74 4/18/25. Review of the undated, Antibiotic Stewardship policy identified the facility would monitor the use of antibiotics by residents, staff would receive education that will include inappropriate use of antibiotics and how they affect residents. The policy did not identify a process of how the infection preventionist should monitor and communicate with the prescribing provider of the effectiveness or appropriateness of the antibiotic prescribed. EMPLOYEE SURVEILLANCE Review of the employee surveillance from January 2025 through March 2025 identified the social services designee (SSD) called in sick on 2/17/25 and was noted to have a a diagnosis of Strep (bacterial throat infection) with a fever of 102 degrees Fahrenheit (F) . There was no last day of work noted, if and/when the SSD returned to work, or if she received any antibiotic therapy. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. The SSD's time card for 2/17/25 identified she	F 882		

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F 882	Continued From page 75 had worked 5 hours on 2/17/25, and returned for a full day (8 hours) on 2/18/25. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to have established policies and procedures for infection control among employees where staff should report their infections or avoid the facility. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. PPE/SOILED LINEN Observation on 4/21/25 at 4:45 p.m., of medication aid (TMA)-B walking down the hallway carrying a ball of rolled up sheets, a reusable pad (used as an additional barrier on residents' beds), and a pair of pants. The clothing and linens were touching her clothing, she dropped the pad on the floor and bent over and picked it back up and continued down the hall to the soiled utility room. Interview on 4/21/25 at 5:20 p.m., with TMA-B confirmed she was carrying the linens and clothing down the hall, the items were touching her clothing, and she had dropped some of them on the floor. She confirmed they were not bagged, and she reported they were soiled with urine. She identified she was aware she was supposed to bag soiled linens before taking them	F 882		

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F 882	Continued From page 76 out of the room due to risk for cross contamination. She identified she normally bags soiled linens but was in a hurry. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control. Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of	F 882		

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F 882	Continued From page 77 the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was responsible for so many other tasks and noted she did not have enough time to complete her duties. "I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working. Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of resistant	F 882		

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F 882	Continued From page 78 strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. The facility was to educate staff and ensure they adhered to proper IC techniques and procedures. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice.	F 882		

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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 4/21/25, through 4/24/25, a standard survey was completed at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B and requirements for Long Term Care Facilities.	2 000		

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2 000	Continued From page 1 The following complaint was reviwed with no deficiencies cited. H53603207C/MN00111095 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced	2 255		5/23/25

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2 255	Continued From page 2 by: Based on interview and record review, the facility failed to provide a Quality Assurance and Performance Improvement (QAPI) plan that identified necessary policies and procedures describing how the facility will identify and correct quality deficiencies. In addition, the facility failed to ensure the quality assurance (QA) team developed, and revised, a quality improvement program to correct infection control concerns identified through tracking and trending and the infection control process as presented by the director of nursing (DON) during routine QAPI meetings.This had the potential to affect all 29 residents residing in the facility. Findings include: QAPI Plan When interviewed on 4/23/25 at 1:29 p.m. the administrator indicated there was no formalized QAPI plan in place to track and measure performance, no goals established to measure performance, and no development or implementation of corrective action or performance improvement activities. The administrator stated although there were attendance rosters available for quarterly QAPI meetings from the past year, the facility lacked any documentation to reflect the QAPI process. The administrator stated awareness of the need for and importance of the QAPI process, however, was new to the facility and this had not yet been implemented. During follow up interview on 4/24/25 at 4:54 p.m., the administrator stated she had again reviewed all documentation in place for QAPI and had not located any information for the past QAPI	2 255	Acknowledged	

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2 255	Continued From page 3 program. The administrator reported information was present for 2023, however, there was not documentation for 2024 to present. During an interview on 4/24/25 at 3:51 p.m., the director of nursing (DON) stated the facility held quality assurance meetings quarterly, which she had attended. The DON stated during these meetings, she presented updates regarding infection control, and current status within the facility. The DON lacked any documentation related to QAPI presentation of information, or of any previous, or current QAPI programs in place. The facility policy and procedure, titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan, updated on 1/2/25, was provided for review. The policy identified facility specific QAPI goals were to implement the QAPI process successfully as evidenced by the formulation of effective Performance Improvement Plans. In addition, the policy identified specific QAPI goals were to be found within the QAPI committee documentation and Performance Improvement Committee(s) documentation. QAPI Improvement Activities On 4/23/25, at 8:28 a.m., the administrator provided information for review related to the Quality Insurance Performance Improvement (QAPI) meeting attendance rosters, and meeting minutes for the current QAPI program. A review of the attendance roster and meeting minutes lacked indication as to what the overall program focused on, as well as what the Performance Improvement Plan (PIP) focus was. The information following the attendance roster of 1/17/24 included hand written notes, however,	2 255		

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2 255	Continued From page 4 these notes provided no context as to what the QAPI program was focusing on, benchmarks and goals, or information regarding the current PIP programs. The minutes did reference infection control, and identified no patterns of infection. The meeting minutes referenced 22 staff days lost [related to illness], and also identified "11 Covid in December". A review of the remainder of the meeting attendance sheets lacked further agendas, meeting minutes, or documentation until 3/19/25. Upon review of the final document provided by the facility, the meeting minutes identified the PIP review as "Anti-psychotic will begin 3/20/25 in weekly meeting." Upon further review, it was noted under the area titled Infection Control, there was "no Covid, four infections, no trends". The document identified the following under the area titled "action plan/follow up" : auditing TB (tuberculosis), PPE (personal protective equipment), Peri-Care audits performed. During follow up interview on 4/23/25 at 4:54 p.m., the administrator stated she was unable to locate any program specific information regarding the QAPI program, or PIP initiatives, prior to her arrival as the administrator approximately one month ago. The administrator stated at this time, the facility is in the beginning stages of formalizing the QAPI program, and development of the PIP. The administrator stated they were planning to utilize the current survey results to identify focus areas for the PIP. The administrator stated upon receipt of the survey results, the QAPI team would review, and further their process at this time. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities	2 255		

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2 255	Continued From page 5 are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide complete information upon transfer to the receiving facility for 1 of 2 residents (R18) reviewed for hospitalization and discharge. Findings include: R18's quarterly Minimum Data Set (MDS) dated	2 690	Acknowledged	5/23/25

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2 690	Continued From page 6 4/10/25, indicated R18 had impaired cognition and was noted to exhibit inattention and disorganized thinking. R18 was also noted to have intermittent behavioral symptoms including physical behavioral symptoms directed towards others, verbal behaviors, and other symptoms not directed at others. R18 was noted to receive assistance with activities of daily living, although was able to ambulate independently. R18's medical diagnoses included acute kidney failure, renal insufficiency, heart failure, hypertension (high blood pressure), Alzheimer's disease, dementia, and depression. A review of Resident Census was completed and it was noted R18 was hospitalized on 3/8/25, however, R18's narrative notes lacked indication as to reason for transfer or what symptoms occurred prior to transfer to the hospital. Upon review of the Resident Census, it was identified resident was returned to the facility on 3/9/25. A review of the narrative progress notes identified documentation from 3/7/25 at 11:37 a.m., which identified a fax was sent to the provider to review the rationale for the use of Seroquel (an antipsychotic medication-a medication to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking). The note indicated the provider was also consulted regarding the possibility of a gradual dose reduction (GDR) at that time. The next narrative note on 3/9/25 at 7:07 p.m., identified R18 was hospitalized however, offered no further information. A subsequent note of 3/9/25 at 1:38 p.m., indicated R18 was hospitalized and was treated for dehydration. The note further indicated orders were received in follow up for physical and occupational therapy.	2 690		

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2 690	Continued From page 7 During interview on 4/24/25 at 3:44 p.m., the assistant director of nursing (ADON) stated R18 was transferred to the emergency room/hospital for evaluation following a fall. A review of the narrative notes with ADON verified there were no notes which reflected the course of events from 3/7/25 to 3/9/25. On 4/24/25, at 4:37 p.m. an interview was held with the director of nursing (DON) to inquired of the circumstances prior to the transfer to the emergency room/hospital. The DON stated R18 had a fall and struck her head. This was identified on the fall and risk management note. R18 was sent in for evaluation and was treated for dehydration. DON stated R18 was sent in for evaluation by a contract (agency staff). DON stated there should have been a narrative progress note to reflect R18's status leading up to the transfer, and additional documentation to indicate the transfer and report to the receiving facility. A review of the scanned documents was completed with the DON with no documentation within the record to provide this information. A document, titled SNF/NF to Hospital Transfer Form was provided to surveyor and was informed by DON this was the information sent to the hospital with R18. This document was completed by registered nurse (RN)-A on 3/8/25 at 12:00 p.m. Although signed off as completed at 12:00 p.m., vital signs were completed within the document at 12:35 p.m.. At that time, R18's blood pressure was 80/54 and a heart rate of 85 beats per minute. The diagnoses provided on the transfer form indicated only chronic obstructive lung disease (a lung problem which causes difficulty breathing) and dementia. The transfer lacked information of acute kidney failure, renal insufficiency, heart failure, hypertension,	2 690		

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2 690	Continued From page 8 Alzheimer's disease, and depression. The document identified R18's most recent pain level was at nine on a scale of one to ten, with ten being the worst pain, however, lacked information as to when the last pain medication was given. The documentation on the form lacked nutritional information, and failed to indicate R18 received a nutritional supplement. The section for medications lacked any medication information. Within the course of the document, there is a page, titled Acute Care Transfer Document Checklist. Although the resident's name, facility name and phone number were present, there was no other information documented as being sent. The options to send information and check off included the R18's Face Sheet (Document which has all medical diagnoses, contact information, and demographic information), current medication listing or medication administration record (medical record which would provide the medications ordered and would identify when last given and next due), and information pertaining to the medical history, including history and physical, recent hospital discharge summary, recent provider notes and orders. The facility policy, Transfer or Discharge, Facility-Initiated, reviewed October of 2022, identified when a resident was transferred from the facility, the receiving facility was to have been provided the following information: documentation of the reason resident needs cannot be met at the facility; contact information of the practitioner responsible for the care of the resident; resident representative contact information; resident status, including baseline information; medications (including when last received); and any other documentation, as applicable to ensure	2 690		

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2 690	Continued From page 9 a safe and effective transition of care. In addition, the policy indicated the following information was to be required in the medical record at the facility: the basis for the transfer; notification to legal representative; the date and time of transfer or discharge; a summary of resident's overall medical, physical, and mental condition; and any other information as necessary. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable policies and procedures to ensure timely completion and sending of resident' data to receiving providers; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 690		
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 ensure nail care was provided for 2 of 5 residents (R20 and R26) Findings include:	2 920	Acknowledged	5/23/25

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2 920	Continued From page 10 R20's 3/27/25, quarterly Minimum Data Set assessment identified he admitted to the facility in September of 2021, his cognition was severely impaired, and he was dependent on staff for activities of daily living (ADL)'s. R20 had diagnoses of Alzheimer's disease, cerebral palsy, bipolar disorder, and arthritis. Interview on 4/21/25 at 12:35 p.m., with family member (FM)-A reported she has asked the facility staff to clean and trim R20's nails several times. She states "his nails look terrible". Observation on 4/21/25 at 12:36 p.m., of R20's nails on both hands were observed to be untrimmed and extended beyond the tip of his fingers with an unknown black substance observed under each nail from edge to edge. Observation on 4/22/25 at 1:23 p.m., of R20's nails identified they remained the same as above. Observation on 4/23/24 at 2:34 p.m., R20's nails remain overgrown with an unknown black substance under the nail of each finger. Review of R20's undated current care plan identified R20 had a self care deficit requiring assistance with ADL's. Staff were to trim and clean his nails as needed two times weekly on bath day. Review of R20's 4/21/25 Nursing Assistant Bath Worksheet identified R21 had his nails trimmed on 4/21/25. The Worksheet was signed by the charge nurse on duty, however, neither the nursing assistant nor the nurse were available for interview. R26's 2/18/25 admission Minimum Data	2 920		

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2 920	Continued From page 11 Assessment identified her cognition was severely impaired, and she had diagnoses of Alzheimer disease, anxiety, depression, and arthritis. Observation on 4/23/25 at 5:08 p.m., R26's nails on both hands were unkept and overgrown approximately 1/4" beyond the tip of her fingers with sharp, broken, crooked edges. All nail has an unknown black dirt like substance under the tip. Review of R26's 4/19/25 Nursing Assistant Bath Sheet identified the nursing assistant completing the bath did not report she had completed nail care. Interview on 4/23/25 at 4:25 p.m., with licensed practical nurse (LPN)-A reported when a nursing assistant completes a bath they fill out a bath sheet to identify if they completed nail care, vitals, and check skin. The bath sheet is given to the charge nurse and recorded in the record. She identified she does not check the resident to ensure nail cares are completed. Interview on 4/23/25 at 4:26 p.m., with registered nurse (RN)-A identified staff do the bath then fill out a bath sheet and returned it to the charge nurse. She would make a progress note and enter the information provided on the form from the nursing assistant. She reported the licensed nurse does not do anything else unless the nursing assistant reports a new skin concern. She stated "I see nail care as a delegation" She did not see the need to follow up to ensure the tasks were been competed. Interview on 4/24/25 at 5:09 p.m., with the facilities RN nursing consultant agreed with the above-mentioned findings and identified she would expect nursing assistants to provide nail	2 920		

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2 920	Continued From page 12 care on bath day and would expect the charge nurse to provide oversite by following up with the resident to ensure the task was completed. A policy was requested but was not provided by the end of the survey period. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for providing nail care as directed by the assessed needs of residents and provide education to nursing staff to follow cares as directed by the care plan. The facility could develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 920		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure cleanliness and monitoring of temps, and undated foods in 1 of 2 refrigerators in dining rooms, and 5 of 5 residents'(R7, R11, R13, R16, and R29) personal refrigerators located in resident rooms.	21100	Acknowledged	5/23/25

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21100	Continued From page 13 Findings include: R16's 3/3/22, quarterly Minimum Data Set (MDS) assessment identified her cognition was intact, she had verbal behaviors towards others two-three days a week, and she was independent with meals and hygiene but required assistance with set up for dressing. R16 had diagnoses of morbid obesity, vascular disease, chronic kidney disease, adjustment disorder, and history of stroke. Observation on 4/22/25 at 5:03 p.m., of R16's room identified she had a small dorm style refrigerator. Inside the refrigerator she had 7 plastic containers with left over foods in them. The containers were not labeled and did not have dates on them. One container had tuna, one container had chicken, and one container had rice. The refrigerator also had condiments and cans of pop. The refrigerator did not have a log to monitor temperature and no thermometer was observed. Interview on 4/23/25 at 7:52 a.m., with the kitchen manager identified nursing is responsible for maintaining personal refrigerators located in resident rooms. Interview on 4/23/25 at 9:33 a.m., with the director of nursing (DON) identified she was not aware that nursing was supposed to monitor the refrigerators in resident rooms for temperature, outdated food, and cleaning. Nursing does monitor the medication room and the dining room refrigerator. She identified she thought it was kitchens responsibility but had just asked them and they said it was nursing's responsibility. She said they had five residents in the facility that had a small refrigerator in their room but she did not	21100		

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21100	Continued From page 14 know if they were being monitored. Observation on 4/23/25 at 10:13 a.m., of the refrigerators located in resident rooms identified the following: 1.) R29's refrigerator did not have anything in it, there was a thermometer located inside fridge but did not have a log to monitor temperatures. 2.) R11's refrigerator contained beef sticks, and an open container of cheese did. There was a thermometer inside the fridge, but no log was observed in the area for monitoring the temperature. 3.) R13's refrigerator was dirty; it had a glass of juice that was not covered and not dated and a banana that had turned completely black. There was a thermometer, but no log observed in the area for monitoring. 4.) R7's refrigerator had cookies and cans of pop in it. There was no thermometer in the fridge and no log observed in the area for monitoring. Observation on 4/23/25 at 10:00 a.m., of the refrigerator located in the memory care resident dining area, had a temp log located on the refrigerator door. The log had a column for daily temperatures in the a.m. and p.m. The April 2025 log had entries indicating the refrigerator temperature from 4/1/25 through 4/23/25 on the following dates and times, 4/1/25 a.m., 4/7/25 p.m., 4/8/25 p.m., 4/13/25 p.m., 4/17/25 p.m. The other 25 days had no documented monitoring of the refrigerator temperatures. The outside of the door had a functioning ice dispenser, that had a black and yellow substance on the lever and the tray beneath. The inside of the freezer was observed to have hair sticking to the shelves and the inside of the door, food crumbs, and a brown sticky substance on the shelves, and a piece of Styrofoam laying in a bin at the bottom of the	21100		

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21100	Continued From page 15 freezer. TMA-B was observed to use the ice dispenser to fill a glass with ice and water and then served it to a resident seated at the table. Interviewed on 4/23/25 at 10:05 a.m., with TMA-B identified she was not sure who was responsible to log the temperatures, but she thought it was the over-night staff. She reported they do not have a cleaning schedule for the refrigerator but they "try to clean it as they go". She looked at the ice dispenser and inside the freezer and agreed the log had not been completed and the freezer and ice dispenser was dirty. Review of the facility provided Refrigerators and Freezers policy dated December 2014, identified the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. The facility would use monthly tracking sheets for all refrigerators and freezers and the logs would be posted. The food service supervisor or designated employees will check and record refrigerator and freezer temperatures daily withy first opening and at closing in the evening. All food shall be appropriately dated to ensure proper rotation by expiration dates and all refrigerators and freezers will be kept clean and free of debris on a scheduled basis. The policy made no mention of personal refrigerators located in resident rooms. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. If the refrigerators/freezers are in the resident areas, dietary and nursing will work together to determine the responsibility for monitoring. The	21100		

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21100	Continued From page 16 facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a current, ongoing system of infection control (IC) surveillance to identify potential outbreaks of infectious disease, analyze data, and track infections through to resolution or identify the need to alter treatment. The facility also failed to ensure employee illnesses were tracked to identify when staff last worked and the criteria for when they would be allowed to return to work. The facility also failed to ensure staff	21375	Acknowledged	5/23/25

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21375	Continued From page 17 appropriately wore a gown (personal protective equipment (PPE)) and/or bagged soiled linen during transport. This had the potential to affect all 29 residents in the facility. In addition, the facility failed to appropriately disinfect 1 of 1 resident's (R7) glucometer prior to returning it to the medication cart, Findings include: RESIDENT INFECTION SURVEILLANCE Review of the infection surveillance logs from January 2025 through March 2025 identified the columns for name, room #, infection date, site of infection, culture taken, causative agent, antibiotic treatment, isolation precautions and center acquired (obtained while in the facility). In January 2025, three residents (R100, R101, and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. Isolation was marked "yes". R100 second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no date identified when R100 was put on precautions, what type of precautions were implemented, what their symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100	21375		

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21375	Continued From page 18 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R101 had a skin infection dated 1/31/25. No culture was marked as taken. Zesorb antifungal medication 2% powder was ordered for 14 days, twice daily. It is unknown where the infection was located, or if it resolved after therapy. 3) R18 was noted to have pneumonia. A culture was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, four residents (R30, R18, R23, and R13) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation as part of infection control surveillance to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the	21375		

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21375	Continued From page 19 progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. 4) R13 was noted to have an infection to a neck surgical incision dated 2/29/25. R13 was given an IV antibiotic. No isolation precautions were noted. R13's progress notes identified R13 had cervical (neck) surgery on 2/6/25 and began showing signs of potential infection on 2/17/25, with surgical site swelling and a non-productive cough was noted. On 2/19/25, R13 had a temperature of 100.4 and complained of vomiting. R13 was sent to the physician's office, who then admitted him to the hospital for treatment. R13 returned to the facility again on 2/24/25 and had a peripherally inserted central catheter (PICC) line (catheter placed into a vein to administer medication directly into the bloodstream for serious infections). There was no indication R13 was placed on enhanced barrier precautions (EBP) upon his return. In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25. The site of the infection was "old peg tube site/skin". No culture was taken. R15 was placed on augmentin (antibiotic). No isolation precautions were noted as having been placed. There was no indication R15 was on enhanced barrier precautions (EBP) prior to the infection to reduce the risk of infection before it had occurred. There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, R16 was placed on augmentin. No isolation precautions were implemented. There	21375		

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21375	Continued From page 20 was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. Review of the National Library of Medicine October- December 2013 article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC3836000/ identified that bacteria was known to be emerging as a multi- resistant pathogen (MDRO). There was no indication R5 was placed on EBP or if the infection preventionist had provided appropriate oversight to ensure the potential to spread the infection was limited or if R5's strain of bacteria was resistant to the antibiotic ordered or if the antibiotic was appropriate. 4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No isolation was noted to be implemented and no culture was noted. There was no indication during any of the above-mentioned surveillance as to whether the infection date was the date when the resident had been diagnosed or if it indicated the onset of symptoms. There was no mention what symptoms each resident had, when transmission based precautions (TBP) were placed or what type of precautions were implemented. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of	21375		

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21375	Continued From page 21 coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of resistant strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. The information obtained from surveillance was to be compared with data from other facilities with use of acknowledged standards and used to assess effectiveness of IC practices. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication. EMPLOYEE SURVEILLANCE Review of the employee surveillance from January 2025 through March 2025 identified the social services designee (SSD) called in sick on 2/17/25 and was noted to have a a diagnosis of Strep (bacterial throat infection) with a fever of 102 degrees Fahrenheit (F) . There was no last day of work noted, if and/when the SSD returned to work, or if she received any antibiotic therapy.	21375		

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21375	Continued From page 22 Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. The SSD's timecard for 2/17/25 identified she had worked 5 hours on 2/17/25, and returned for a full day (8 hours) on 2/18/25. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to have established policies and procedures for infection control among employees where staff should report their infections or avoid the facility. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. PPE/SOILED LINEN Observation on 4/21/25 at 4:45 p.m., of	21375		

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21375	Continued From page 23 medication aid (TMA)-B walking down the hallway carrying a ball of rolled up sheets, a reusable pad (used as an additional barrier on residents' beds), and a pair of pants. The clothing and linens were touching her clothing, she dropped the pad on the floor and bent over and picked it back up and continued down the hall to the soiled utility room. Interview on 4/21/25 at 5:20 p.m., with TMA-B confirmed she was carrying the linens and clothing down the hall, the items were touching her clothing, and she had dropped some of them on the floor. She confirmed they were not bagged, and she reported they were soiled with urine. She identified she was aware she was supposed to bag soiled linens before taking them out of the room due to risk for cross contamination. She identified she normally bags soiled linens but was in a hurry. Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented	21375		

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21375	Continued From page 24 infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was responsible for so many other tasks and noted she did not have enough time to complete her duties. "I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working. Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to educate staff and ensure they adhered to proper IC techniques and procedures.	21375		

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21375	Continued From page 25 There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control. Glucometer cleaning R7's significant change Minimum Data Set assessment of 1/28/25, indicated R7 had moderate cognitive impairment. R7 was identified as receiving help with activities of daily living. R7's medical diagnoses included diabetes (a group of diseases that affect how the body uses blood sugar (glucose), as well as endocrine (the system which released hormones into your blood while continuously monitoring the levels), nutritional, and metabolic diseases (any of the diseases or disorders that disrupt normal metabolism, the process of converting food to energy on a cellular level). On 4/22/25 at 4:30 p.m., licensed practical nurse (LPN)-A was observed during routine medication pass. At this time, R7 was due for blood sugar monitoring (checking the level of blood sugar in the blood to help determine if medication or additional interventions are needed). LPN-A performed hand hygiene and set up equipment to complete blood sugar check, using R7's monitor. LPN-A brought gloves to room along with	21375		

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21375	Continued From page 26 equipment, and donned gloves before starting the procedure. R7's finger was cleansed with an alcohol prep, blood was drawn with the use of a disposable lancet (needle used for blood sugar checks), and blood sugar was checked with glucometer (a machine used to check blood sugars). LPN-A gathered supplies and exited room. The lancet was disposed of appropriately, machine was placed on cart, gloves removed and hand hygiene performed. LPN-A then applied gloves and wiped the machine with an alcohol wipe to clean/sanitize the machine. LPN-A stated this was the process she was trained in when she started at the facility. LPN-A proceeded to return the machine to the med cart in the area designated for R7's machine. LPN-A then removed gloves and performed hand hygiene before proceeding to the next task. On 4/22/25, at 4:35 p.m., an interview was held with the director of nursing (DON) to inquire of the process for sanitizing glucometers following performing a blood glucose test. DON stated the glucometer should be cleaned with the use of a disinfectant wipes, wrapping the glucometer in the wipe and allowing to dry to complete the sanitation process. Nurse Consultant (NC) was also present at this time and verified EPA (Environmental Protection Agency) approved wipes should be used for sanitation. The facility policy, Blood Glucose Monitoring Policy and Protocol, undated, identified "All glucometers will be cleaned per manufacturer recommendations prior to performing bedside test. The policy then later identified "The glucometer will be cleaned prior to each use and after each use per manufacturer recommendation." The policy lacked indication as to what product was to be used with cleaning,	21375		

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21375	Continued From page 27 aside from identifying per manufacturers recommendations. The manufacturer's policy for the glucometer, with the recommendations for cleaning, was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for infection control program to include tracking, evaluating, interventions to prevent the spread of infection. The director of nursing, or designee, could assure the appropriate processes are in place of for sanitizing of equipment according to best practices, and manufacturers recommendations. In addition, the director of nursing and infection control preventionist could review/revise antibiotic stewardship policies and procedures and provide staff education for implementation of antibiotic stewardship practices. The director of nursing, or designee, could perform random audits to assure practices were being implemented appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control;	21390		5/23/25

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21390	Continued From page 28 E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a current, ongoing system of infection control (IC) surveillance to identify potential outbreaks of infectious disease, analyze data, and track infections through to resolution or identify the need to alter treatment. The facility also failed to ensure employee illnesses were tracked to identify when staff last worked and the criteria for when they would be allowed to return to work. The facility also failed to ensure staff appropriately wore a gown (personal protective equipment (PPE)) and/or bagged soiled linen during transport. This had the potential to affect all 29 residents in the facility. In addition, the facility failed to appropriately disinfect 1 of 1 resident's (R7) glucometer prior to returning it to the medication cart, Findings include:	21390	Acknowledged	

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21390	Continued From page 29 RESIDENT INFECTION SURVEILLANCE Review of the infection surveillance logs from January 2025 through March 2025 identified the columns for name, room #, infection date, site of infection, culture taken, causative agent, antibiotic treatment, isolation precautions and center acquired (obtained while in the facility). In January 2025, three residents (R100, R101, and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. Isolation was marked "yes". R100 second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no date identified when R100 was put on precautions, what type of precautions were implemented, what their symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R101 had a skin infection dated 1/31/25. No culture was marked as taken. Zesorb antifungal medication 2% powder was ordered for 14 days, twice daily. It is unknown where the infection was located, or if it resolved after therapy. 3) R18 was noted to have pneumonia. A culture	21390		

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21390	Continued From page 30 was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, four residents (R30, R18, R23, and R13) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation as part of infection control surveillance to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. 4) R13 was noted to have an infection to a neck surgical incision dated 2/29/25. R13 was given an IV antibiotic. No isolation precautions were noted.	21390		

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21390	Continued From page 31 R13's progress notes identified R13 had cervical (neck) surgery on 2/6/25 and began showing signs of potential infection on 2/17/25, with surgical site swelling and a non-productive cough was noted. On 2/19/25, R13 had a temperature of 100.4 and complained of vomiting. R13 was sent to the physician's office, who then admitted him to the hospital for treatment. R13 returned to the facility again on 2/24/25 and had a peripherally inserted central catheter (PICC) line (catheter placed into a vein to administer medication directly into the bloodstream for serious infections). There was no indication R13 was placed on enhanced barrier precautions (EBP) upon his return. In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25. The site of the infection was "old peg tube site/skin". No culture was taken. R15 was placed on augmentin (antibiotic). No isolation precautions were noted as having been placed. There was no indication R15 was on enhanced barrier precautions (EBP) prior to the infection to reduce the risk of infection before it had occurred. There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, R16 was placed on augmentin. No isolation precautions were implemented. There was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. Review of the National Library of Medicine October- December 2013 article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC383600	21390		

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21390	Continued From page 32 0/ identified that bacteria was known to be emerging as a multidrug resistant pathogen (MDRO). There was no indication R5 was placed on EBP or if the infection preventionist had provided appropriate oversight to ensure the potential to spread the infection was limited or if R5's strain of bacteria was resistant to the antibiotic ordered or if the antibiotic was appropriate. 4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No isolation was noted to be implemented and no culture was noted. There was no indication during any of the above-mentioned surveillance as to whether the infection date was the date when the resident had been diagnosed or if it indicated the onset of symptoms. There was no mention what symptoms each resident had, when transmission based precaustions (TBP) were placed or what type of precautions were implemented. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of	21390		

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21390	Continued From page 33 infections is optimal, whether antibiotic usage patterns need to be changed because of resistant strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. The information obtained from surveillance was to be compared with data from other facilities with use of acknowledged standards and used to assess effectiveness of IC practices. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication. EMPLOYEE SURVEILLANCE Review of the employee surveillance from January 2025 through March 2025 identified the social services designee (SSD) called in sick on 2/17/25 and was noted to have a a diagnosis of Strep (bacterial throat infection) with a fever of 102 degrees Fahrenheit (F) . There was no last day of work noted, if and/when the SSD returned to work, or if she received any antibiotic therapy. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for	21390		

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21390	Continued From page 34 spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. The SSD's timecard for 2/17/25 identified she had worked 5 hours on 2/17/25, and returned for a full day (8 hours) on 2/18/25. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to have established policies and procedures for infection control among employees where staff should report their infections or avoid the facility. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. PPE/SOILED LINEN Observation on 4/21/25 at 4:45 p.m., of medication aid (TMA)-B walking down the hallway carrying a ball of rolled up sheets, a reusable pad (used as an additional barrier on residents' beds), and a pair of pants. The clothing and linens were touching her clothing, she dropped the pad on the floor and bent over and picked it back up and continued down the hall to the soiled utility room.	21390		

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21390	Continued From page 35 Interview on 4/21/25 at 5:20 p.m., with TMA-B confirmed she was carrying the linens and clothing down the hall, the items were touching her clothing, and she had dropped some of them on the floor. She confirmed they were not bagged, and she reported they were soiled with urine. She identified she was aware she was supposed to bag soiled linens before taking them out of the room due to risk for cross contamination. She identified she normally bags soiled linens but was in a hurry. Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was	21390		

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21390	Continued From page 36 responsible for so many other tasks and noted she did not have enough time to complete her duties. "I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working. Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to educate staff and ensure they adhered to proper IC techniques and procedures. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the	21390		

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21390	Continued From page 37 infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control. Glucometer cleaning R7's significant change Minimum Data Set assessment of 1/28/25, indicated R7 had moderate cognitive impairment. R7 was identified as receiving help with activities of daily living. R7's medical diagnoses included diabetes (a group of diseases that affect how the body uses blood sugar (glucose), as well as endocrine (the system which released hormones into your blood while continuously monitoring the levels), nutritional, and metabolic diseases (any of the diseases or disorders that disrupt normal metabolism, the process of converting food to energy on a cellular level). On 4/22/25 at 4:30 p.m., licensed practical nurse (LPN)-A was observed during routine medication pass. At this time, R7 was due for blood sugar monitoring (checking the level of blood sugar in the blood to help determine if medication or additional interventions are needed). LPN-A performed hand hygiene and set up equipment to complete blood sugar check, using R7's monitor. LPN-A brought gloves to room along with equipment, and donned gloves before starting the procedure. R7's finger was cleansed with an alcohol prep, blood was drawn with the use of a disposable lancet (needle used for blood sugar checks), and blood sugar was checked with glucometer (a machine used to check blood sugars). LPN-A gathered supplies and exited room. The lancet was disposed of appropriately,	21390		

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21390	Continued From page 38 machine was placed on cart, gloves removed and hand hygiene performed. LPN-A then applied gloves and wiped the machine with an alcohol wipe to clean/sanitize the machine. LPN-A stated this was the process she was trained in when she started at the facility. LPN-A proceeded to return the machine to the med cart in the area designated for R7's machine. LPN-A then removed gloves and performed hand hygiene before proceeding to the next task. On 4/22/25, at 4:35 p.m., an interview was held with the director of nursing (DON) to inquire of the process for sanitizing glucometers following performing a blood glucose test. DON stated the glucometer should be cleaned with the use of a disinfectant wipes, wrapping the glucometer in the wipe and allowing to dry to complete the sanitation process. Nurse Consultant (NC) was also present at this time and verified EPA (Environmental Protection Agency) approved wipes should be used for sanitation. The facility policy, Blood Glucose Monitoring Policy and Protocol, undated, identified "All glucometers will be cleaned per manufacturer recommendations prior to performing bedside test. The policy then later identified "The glucometer will be cleaned prior to each use and after each use per manufacturer recommendation." The policy lacked indication as to what product was to be used with cleaning, aside from identifying per manufacturers recommendations. The manufacturer's policy for the glucometer, with the recommendations for cleaning, was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies and procedures for	21390		

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21390	Continued From page 39 infection control surveillance and data collection/analysis, appropriate sanitization of equipment, and antibiotic stewardship and provide education to staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending	21530		5/23/25

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21530	Continued From page 40 physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure pharmacy consultant recommendations were followed up on in a timely manner for 1 of 5 residents (R13) reviewed for pharmacy recommendations.. Findings include: R13's 3/12/25, quarterly Minimum Data Set (MDS) assessment identified his cognition was intact, he had no behaviors, and he was independent with activities of daily living (ADL)'s. R13 had diagnoses of adjustment disorder with depressed mood, hypertension, diabetes, anxiety, orthostatic hypotension, repeated falls, and stroke. Review of R13's pharmacy consultants monthly drug regimen review identified the following: 1. October 2024 pharmacy consultant recommendation: Please assess for continued use of divalproex 250 mg twice daily, CMS guidelines recommend periodic reassessment of psychotropic medication for trial dose reduction consideration in attempts to eventually discontinue unnecessary psychotropics or find	21530	Acknowledged	

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21530	Continued From page 41 lowest effective dose. If current dose is still appropriate for patient, please provide clinical rationale for continuing current dose in the patient medical record. Physician to address ASAP but no later than 60 days. The facility was unable to provide documentation showing the October review had been addressed by the physician or that the physician had been updated. 2. November 2024 pharmacy consultant recommendation: Please assess for continued use of divalproex 250 mg twice daily, CMS guidelines recommend periodic reassessment of psychotropic medication for trial dose reduction consideration in attempts to eventually discontinue unnecessary psychotropics or find lowest effective dose. If current dose is still appropriate for patient, please provide clinical rationale for continuing current dose in the patient medical record. Physician to address ASAP but no later than 60 days. The November review provided again had no indication that the physician had been updated. 3. January 2025 pharmacy consultant recommendation: Prednisone oral tablet 20 mg give 40 mg by mouth in the morning for preoperative dose related to irritable bowel syndrome, unspecified for three days. Prednisone oral tablet 5 mg Give 20 mg by mouth in the morning for preoperative exam prep for three days Prednisone oral tablet 5 mg, Give 20 mg by mouth in the morning for three days. Please verify if patient should be taking 20 mg, 40 mg, or 60 mg of prednisone for pre-op. Also, should he take 5 mg dose as well those days? The January pharmacy consultant recommendations did not include a response or signature from the physician. 4. February 2025 pharmacy consultant recommendation was to add a diagnosis for the	21530		

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21530	Continued From page 42 use of: prednisone oral tablet 5 mg (prednisone) 5 mg by mouth in the morning. Pyridostigmine bromide oral tablet 60 mg (pyridostigmine Bromide) Give 1 tablet by mouth three times of day. The facility was unable to provide any documentation to show they had updated the physician. Review of the provided copy of the pharmacy review did not include a physician signature. Interview on 4/24/25 at 9:03 a.m., with the director of nursing identified she agreed with the above findings. She reported she does not have a good process in place and would like some help with getting these pharmacy consultant medication reviews organized. Interview on 4/24/25 at 5:00 p.m., with the nurse consultant identified she agreed with the above findings, she reported she has also looked for the documentation showing they had updated the physician and she was also unable to locate it in the medical record. It is her expectation the facility follow-up with the physician once they receive the monthly pharmacy consultant reviews, she would expect this to be completed timely and the facility should have a process to maintain this documentation in an organized fashion. A policy was requested but nothing was provided by the end of the survey period. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable procedures and policies to ensure the timely acting upon pharmacist recommendations; the	21530		

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21530	Continued From page 43 educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		5/23/25

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21545	Continued From page 44 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physicians orders and manufacturers guidelines for 2 of 7 (R24 and R30) residents observed to receive medications. A total of seven (7) errors out of 26 errors were identified, resulting in a 26.9% (percent) facility error rate. Findings include: On 4/22/25 at 3:56 p.m., licensed practical nurse (LPN-A) was observed to prepare medications at a mobile medication cart in the hallway of the unit. R24 was in the hallway and approached the medication cart for medication administration. LPN-A proceeded to set up medications, including topical medication Voltaren External Gel 1 % (Diclofenac Sodium). The label for this prescription cream directed staff to apply two gm (grams). LPN-A stated she did not have the dispensing film to measure out the two grams as ordered, however, R24 only wished to receive a	21545	Acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 04/24/2025

PENDING ACKNOWLEDGEMENT

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GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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21545	Continued From page 45 pea sized amount. LPN-A was unsure how much this was comparative to the two grams amount ordered. LPN-A stated the order on the med sheet, as well as on the label was to be administered, however, R24 preferred only a smaller amount. Immediately following observation of administration of medications, a review was completed of R24's electronic medical record, and Medication Administration Record. A review of the electronic Medication Administration Record indicated the following order: Voltaren External Gel 1 % Diclofenac Sodium (Topical); Apply to knees topically three times a day for knee pain. Apply 2 grams to affected joints. The start date for this order was 10/11/24. Upon review of the Voltaren gel information on https://www.drugs.com/dosage/voltaren-gel, it was identified the 2-gram line is 2.25 inches long. R30's Order Summary Report, dated 4/24/25, identified R30's current physician-ordered medications and treatments. These orders included the orders for Aspirin Delayed Release 325 mg by mouth in the morning for pain with order date of 1/15/25. The orders also included Colace (Docusate sodium) 100 mg by mouth twice a day for stool softener, effective 1/15/25. R30 had orders also noted for Furosemide 20 mg by mouth every morning for tachy-brady syndrome and edema (swelling) effective 3/12/25. R30 had orders in place for Gabapentin 100 mg capsule ordered twice daily by mouth for pain effective 1/22/25. Additional orders were in place for Metoprolol 25 mg twice daily by for essential hypertension, effective 1/21/25. The orders directed staff to give with food. R30 also had orders in place, effective 1/22/25, for Tylenol	21545		

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21545	Continued From page 46 (acetaminophen) 500 mg two tablets three times a day for pain management. The orders also included Vitamin D3/cholecalciferol (2000 IU)/50 mcg (a unit of measurement) one tablet daily for Vitamin D deficiency, effective 3/6/25. The orders also identified orders for Potassium Chloride Crystals ER (Extended Release) (K-Cl ER) 20 mEq by mouth in the morning for mineral balance. R30's EMAR, printed 4/24/25, identified the above listed medications. The instructions outlined on the EMAR lacked any additional instructions for administration of medications. The EMAR lacked direction to the staff to crush medications and mix with applesauce prior to administration. On 4/23/25, at 7:29 a.m. TMA-B prepared R30's medication at a mobile cart in the hallway near the nurses station. TMA-B proceeded to set up medications for R30 upon review of the EMAR. TMA-B informed surveyor medications were crushed for R30. The following medications were removed from the med cart, compared to the EMAR for accuracy, and set up by TMA-B: Aspirin (ASA) 325 mg one tablet daily by mouth; Colace (Docusate Sodium) 100 mg one tablet twice daily by mouth; Furosemide 20 mg one tablet daily in the morning by mouth; Metoprolol 25 mg one tablet twice daily by mouth; Acetaminophen 500 mg two tablets three times a day; and Vitamin D3/cholecalciferol (2000 IU)50 mcg one. Upon preparation of the Gabapentin 100 mg one capsule twice daily by mouth, the capsule was opened and contents placed into applesauce. TMA-B prepared the K-Cl ER 20 mEq one tablet every morning by mixing this with a small amount of water to prepare a slurry (dissolving the medication in water to give in a	21545		

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21545	Continued From page 47 suspension). Upon setting up all medications as outlined, with the exception of the Gabapentin and K-Cl ER, the medications were subsequently crushed and placed into applesauce. The medications were then administered to R30. On 4/23/25, at 12:50 p.m. TMA-B was interviewed in follow up regarding the process to determine whether or not to crush meds. TMA-B stated she knew orders to crush medications came from therapy (speech therapy). TMA-B stated the staff would perform a trial to see what worked best for the resident, then a crush order would be obtained if indicated. TMA-B stated she was unsure where the order was found on the electronic medical records (EMR). TMA-B stated this information was relayed to the oncoming staff at shift reports. The information was also displayed on the resident "banner" within the EMR, and was generally noted in red. Upon review of the banner for R30, TMA-B stated the order crush meds was not observed in the "banner". On 4/23/25, at 1:50 p.m. inquired of TMA-B if there have been any problems to date with administration of crushed meds for R30. TMA-B stated R30 had no problems with crushed meds. On 4/24/25, at 3:45 p.m. the assistant director of nursing (ADON) stated the provider must provide the order allowing crushed meds before this would be initiated. The ADON went on to say medications would then be crushed unless it was contraindicated to do so. The ADON stated this order would be placed on the order sheet, and would be found under "Other orders". If the orders were entered correctly, it would also be displayed on the resident banner in the EMR. A review of the R30's EMR lacked indication of orders by the provider, as well as information in	21545		

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21545	Continued From page 48 the banner regarding authorization to crush medications. During interview on 4/24/25, at 3:51 p.m., the director of nursing (DON) stated orders must have been obtained from the provider before medications were given crushed. The assistant director of nursing (ADON) was in the office during this discussion, and upon review of the concerns regarding crushing of meds for R30, verified there were no orders in place in the EMR. In regards to R24, DON stated medications were to be given as prescribed. DON stated if a lesser dose was requested, as in the Diclofenac amount for R24, the provider was to be contacted in update and an alternate order was to be obtained. On 4/23/25, at 4:17 p.m. the consulting pharmacist (CP) was provided an overview of the medications being given without a provider order to crush medications. CP stated a provider order was needed before medications were crushed and given to the resident, and medications were not to be given crushed without first consulting the provider. CP stated prior to authorization to crush the medication, the provider reviewed the residents medication and a determination would need to be made as to if the medications were acceptable to crush. If the provider deemed it was not appropriate to crush medications, an alternate method of administration/or alternate medication with a different delivery source would need to be considered. A review was completed with the medications which were given crushed. CP stated upon review of the medications, CP stated ASA was a medication which was not to be crushed. When asked if this was considered a significant medication error, CP stated she did not wish to give things a label.	21545		

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21545	Continued From page 49 A facility policy, noted to have been revised April 2018, indicated "The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify the appropriate indications and procedures for crushing medications." The policy identified the order to crush medications must come from the physician. The policy identified the MAR or other documentation must indicate why it was necessary to crush the medication. A facility policy, titled Administering Medications, last revised December 2012. identified: If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on ensuring timely and accurate delivery of medications; then inservice direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21545		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		5/23/25

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21620	Continued From page 50 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed medications were labeled with current physician-ordered administration instructions to reduce the risk of administration error for 1 of 6 residents (R24) observed to receive medication during the survey. Findings include: R24's quarterly Minimum Data Set (MDS), dated 12/3/24, identified R24 had intact cognition with several medical diagnoses which included a medically complex condition, restless leg syndrome, muscle weakness, and difficulty walking. On 4/22/25 at 3:56 p.m., licensed practical nurse (LPN-A) was observed to prepare medications at a mobile medication cart in the hallway of the unit. R24 was in the hallway and approached the medication cart for medication administration. LPN-A proceeded to set up medications, including obtaining the med card for Tramadol from the locked box. LPN-A stated R24 received Tramadol HCl 50 mg one tablet every eight (8) hours, and this was given on a routine basis.. A review of the label indicated the dosing for the medication was for every eight hours, as needed, and did not identify that it was scheduled. LPN-A reviewed electronic medical record with surveyor, and orders reflected the order was for three times a day, and was not listed as a medication to be given as needed. LPN-A stated the label on the prescriptions were to accurately reflect the orders for the medications by the provider and indicated she was going to send a request to pharmacy for a label change to accurately reflect orders. A	21620	Acknowledged	

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21620	Continued From page 51 review of the electronic Medication Administration Record indicated the following orders: Tramadol HCl 50 mg one tablet by mouth three times daily. The start date of the prescription was on 8/31/24. A review of the R24's orders printed 4/24/25, identified R24 was to receive Tramadol HCl one tablet by mouth three times a day for pain effective 8/30/24, with a start date of 8/31/24. On 4/24/25 at 3:51 p.m., the director of nursing was interviewed regarding medication labeling and label checks during medication administration. DON stated the medication labels were to reflect current order. DON stated if a discrepancy was noted, the staff were to verify the correct dose ordered and request a label correction as needed. DON stated medications are to be given as prescribed. A facility policy, titled Administering Medications, last revised December 2012. identified: Medications shall be administered in a safe and timely manner, and as prescribed. The policy directs staff "must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for consistent review of labeling of medications for accuracy. Nursing staff could be educated as necessary of the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one	21620		

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21620	Continued From page 52 (21) days.	21620		
21720	MN Rule 4658.1415 Subp. 9 Plant Housekeeping, Operation, & Maintenance Subp. 9. Storage of supplies. Supplies must be stored above the floor to facilitate cleaning of the storage area. Supplies must be identified. Toxic substances must be clearly identified and stored in a locked enclosure. Sterile supplies must be stored to maintain sterility and integrity in packaging. All substances, such as cleaning agents, bleaches, detergents, disinfectants, pesticides, paints, and flammable liquids, must be stored separately from all food and drugs. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure hazardous chemicals were appropriately secured in 1 of 2 unlocked soiled utility rooms located in hall A. This had the potential to affect 16 of 29 residents residing in that hall. Findings include: Observation on 4/21/25 at 1:49 p.m., of the unlocked soiled utility room a bottle of Lysol toilet bowl cleaner was sitting on the counter next to the sink. Some of the cleaner was spilled on the countertop. Interview on 4/21/25 at 1:54 p.m., with the maintenance director confirmed the above findings. He does walk through the building but was unable to recall the last time he had checked the utility rooms. He identified they have a locked	21720	Acknowledged	5/23/25

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21720	Continued From page 53 closet off the nursing floor that is supposed to be used to store cleaning supplies and other hazardous chemicals. He was not certain who had left the toilet bowl cleaner in the unlocked utility room. Interview on 4/24/25 at 4:58 p.m., with the nurse consultant and administrator identified they would expect staff to ensure all hazardous chemicals are always kept in a locked closet away from the resident areas to ensure there was no risk of injury. Review of the 2017 Hazardous Areas, Devices and Equipment policy identified the facility will be assessed for hazards on an on-going basis. When a hazard is identified the safety committee will give recommendations for measures to ensure that vulnerable residents cannot access hazardous areas in the facility with locks, alarms, supervision, etc. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could ensure safe storage of chemicals was maintained and inspection program was developed, scheduled and audited. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21720		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and	21915		5/23/25

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21915	Continued From page 54 their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish a family council within the past 12 months. This had the potential to affect 29 residents residing in the facility. Findings include: During interview on 4/22/25 at 5:50 p.m., the administrator stated the last attempt to establish a Family Council was with a letter in outreach to family members on 11/21/23. The administrator stated there was no response to the letter at that time. The administrator verified there is no Family Council in place at this time. The administrator stated a letter in outreach has not been sent out in follow up. A facility policy regarding family council was requested but not provided. SUGGESTED METHOD OF CORRECTION: The facility's social worker or social service designee could contact resident family members via any method, to invite to participate in a family council meeting. The frequency of the family council	21915	Acknowledged	

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21915	Continued From page 55 meetings could be determined by the family council. Documentation of all meetings and attempts should be maintained. If the first attempt does not yield results, the facility could make another attempt later in the same year. The administrator or designee could monitor the attempts to organize a family council. TIME PERIOD: Twenty-one (21) days	21915		

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

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	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2025**

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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 04/23/2025. At the time of this survey, Glenoaks Senior Living Campus was found not 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, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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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GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Glenoaks Senior Living Campus The facility has a capacity of 52 beds and had a census of 29 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2025**

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K 131	Continued From page 2	K 131		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a two-hour rated fire wall and fire rated doors in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.1.1.4, 19.1.1.4.1, 8.3, 8.3.1, 8.3.1.2, 8.3.2, 8.3.2.1 and 8.3.5. This deficient practice could have a widespread impact on the residents within the facility. Findings include:	K 131	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does conduct facility checks for improperly sealed penetrations.	5/23/25

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K 131	Continued From page 3 1. On 04/23/25 between 9:00 AM and 12:30 PM, it was revealed by observation that above the ceiling at the 2-hour rated fire wall in between the assisted living and Maple wing in the nursing home a hole penetrated by a cable was not properly fire stopped. This deficient finding was confirmed by the Environmental Services Director at the times of discovery.	K 131	"The penetration in between the assisted living and maple wing in the nursing home was fire stopped by sealing with fire caulk. "All residents and staff have the potential to be affected in the event of a fire. "Maintenance staff were re-educated on the importance of maintaining fire barrier integrity and inspecting any new or modified penetrations. Maintenance Director or Designee will inspect any new or modified penetrations resulting from work performed at the facility and findings will be brought to the QAA committee for review.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324		5/23/25

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K 324	Continued From page 4 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.5, 9.2.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: 1. On 04/23/2025 between 9:00 AM and 12:30 PM, it was revealed during documentation review that the facility could not provide documentation that the range hood suppression system was being inspected every 6 months. This deficient finding was confirmed by the Environmental Services Director at the time of discovery.	K 324	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does conduct inspections every six months on the range hood suppression. " The range hood suppression was inspected on 2/17/25. " All residents and staff have the potential to be affected if range hood suppression is not inspected every six months. " Maintenance staff were re-educated on the importance of ensuring inspections are conducted per regulations and, to maintain all documentation in a designated binder. Administrator or Designee will audit the documentation binder every six months to ensure the range hood suppression is	

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K 324	Continued From page 5	K 324	inspected per regulations and with the proper documentation present and findings will be brought to the QAA committee for review.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code sections 14.2.1.1.2 and 14.2.1.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 9:00 AM and 12:30 PM, it was revealed by observation that there was a trouble signal on the fire panel labeled "Integrated Power Supply". This deficient finding was confirmed by the Environmental Services Director at the time of discovery.	K 345	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does maintain the fire alarm system in accordance with an approved program that is following the compliance requirements. " GlenOaks was aware that there was a trouble signal on the fire panel labeled Integrated Power Supply. Summit Fire Protection was called immediately after the fire panel signaled the issue. Summit responded to the facility and stated that	6/20/25

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K 345	Continued From page 6	K 345	the facility needed a new fire panel. Summit stated that this issue did not affect the integrity of the fire alarm system, sprinkler system, or notification to the fire department in event of a fire. A new fire panel was ordered. At the time of the survey the facility was waiting for the new fire panel to be delivered and installed. " All residents and staff have the potential to be affected if the fire panel is not functioning properly. " GlenOaks acted immediately when the trouble signal sounded and displayed the message. This will continue to be the protocol moving forward. Maintenance Director or Designee will continue to monitor the fire panel for any issues that may occur in the future and take appropriate action. Findings will be brought to the QAA committee for review.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		5/23/25

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K 353	Continued From page 7 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.3, 4.4, 4.7 and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 26.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/23/2025 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation for quarterly sprinkler inspections for the 3rd and 4th quarter. 2. On 04/23/2025 between 09:00 AM and 12:30 PM, it was revealed by observation that there was missing ceiling tiles located in the houskeeping closet in the employee entrance. These deficient findings were confirmed by the Environmental Services Director at the time of discovery.	K 353	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. 1. GlenOaks Senior Living Campus does quarterly sprinkler inspections. " The sprinklers were inspected on 2/10/25 " All residents and staff have the potential to be affected if the sprinkler system is not inspected quarterly. " Maintenance staff were re-educated on the importance of ensuring inspections are conducted per regulations and, to maintain all documentation in a designated binder. Administrator or Designee will audit the documentation binder quarterly to ensure sprinkler inspections are completed per regulations and with the proper documentation present and findings will be brought to the QAA committee for review.	

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K 353	Continued From page 8	K 353	2. GlenOaks Senior Living Campus does ensure that there are no missing ceiling tiles. " The missing ceiling tiles in the housekeeping closet in the employee entrance were replaced and a facility inspection was conducted to ensure there were no other missing ceiling tiles. " All residents and staff have the potential to be affected in the event of a fire. " Maintenance staff were re-educated on the importance of ensuring ceiling tiles are present throughout the facility Maintenance Director or Designee will audit monthly to ensure ceiling tiles are present throughout the facility and findings will be brought to the QAA committee for review.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.2.5.3.8 and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. This deficient finding could have a patterned impact on the residents within the	K 355	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law.	5/23/25

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K 355	Continued From page 9 facility. Findings include: On 04/23/2025 between 09:00 AM and 12:30 PM, it was revealed by observation that the extinguisher in the boiler and therapy rooms had not been inspected monthly. This deficient finding was confirmed by the Environmental Services Director at the time of discovery.	K 355	GlenOaks Senior Living Campus does inspect all fire extinguishers every month. " The fire extinguisher in the boiler and therapy rooms were inspected. Maintenance created a spreadsheet listing all fire extinguishers and their location. The spreadsheet will be utilized each month to ensure all fire extinguishers are inspected. " All residents and staff have the potential to be affected if the fire extinguishers are not inspected. " Maintenance staff were re-educated on the importance of inspecting fire extinguishers per regulations and, to maintain all documentation in a designated binder. Administrator or Designee will audit the fire extinguisher spreadsheet monthly to ensure all fire extinguishers are inspected every month with the proper documentation present for 6 months and findings will be brought to the QAA committee for review.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone	K 711		5/23/25

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K 711	Continued From page 10 operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 09:00 AM and 12:30 PM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include transmission of alarms to fire department. This deficient finding was confirmed by the Environmental Services Director at the time of discovery.	K 711	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus fire safety plan does state, the fire alarm system is connected to the fire department and automatically sounds an alarm at the fire station when a pull station is activated. The current fire safety plan was located and provided to the Maintenance Director. " All residents and staff have the potential to be affected if current policies and procedures are not enacted. " Maintenance staff were re-educated on where to locate the latest policies and procedures. Administrator reviewed the maintenance binder to ensure all policies were current. When policies are updated the administrator will ensure maintenance is notified and findings will be brought to the	

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K 711	Continued From page 11	K 711	QAA committee for review	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the months of June, July, October, November, and December 2024. This deficient finding was confirmed by the Environmental Services Director at the time of	K 712	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does perform fire drills every month per regulations. " Fire drills were conducted with documentation. " All residents and staff have the potential to be affected if fire drills do not occur per regulations. " Maintenance staff were re-educated on	5/23/25

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K 712	Continued From page 12 discovery.	K 712	the importance of ensuring fire drills are conducted per regulations and, to maintain all documentation in a designated binder. Administrator or Designee will audit the fire drill documentation monthly to ensure all fire drills are conducted per regulations with the proper documentation present every month for 6 months and findings will be brought to the QAA committee for review.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 914		5/23/25

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K 914	Continued From page 13 by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide updated documentation for resident room electrical receptacle testing. This deficient finding was confirmed by the Environmental Services Director at the time of discovery.	K 914	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does perform resident room electrical receptacle testing. " Resident room electrical receptacle testing and repairs have been completed. " All residents and staff have the potential to be affected if receptacle testing does not occur per regulations. " Maintenance staff were re-educated on the importance of ensuring inspections are conducted per regulations and, to maintain all documentation in a designated binder. Maintenance Director or designee will place a calendar reminder for testing per regulations and findings will be brought to the QAA committee for review.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		5/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 14 criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2 and 8.4.1. These deficient findings could have a widespread impact on the residents	K 918	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE NEW LONDON, MN 56273**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 15 within the facility. Findings include: 1. On 04/23/2025 between 09:00 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the generator had been being tested monthly. 2. On 04/23/2025 between 09:00 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the generator had been being tested weekly. 3. On 04/23/2025 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability from the gas company. These deficient findings were confirmed by the Environmental Services Director at the time of discovery.	K 918	1. GlenOaks Senior Living Campus does perform monthly generator testing. " April monthly generator testing was conducted and documented. " All residents and staff have the potential to be affected if the generator is not tested monthly. " Maintenance staff were re-educated on the importance of ensuring inspections are conducted per regulations and, to maintain all documentation in a designated binder. Administrator or Designee will audit the generator testing documentation monthly to ensure all testing is conducted per regulations with the proper documentation present every month for 6 months and findings will be brought to the QAA committee for review. 2. GlenOaks Senior Living Campus does perform weekly generator testing. " Weekly generator testing is occurring and being documented. " All residents and staff have the potential to be affected if the generator is not tested weekly. " Maintenance staff were re-educated on the importance of ensuring inspections are conducted per regulations and, to maintain all documentation in a designated binder. Administrator or Designee will audit the generator testing documentation monthly to ensure all testing is conducted weekly with the proper documentation present every month for 6 months and findings will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 918	Continued From page 16	K 918	be brought to the QAA committee for review. 3. GlenOaks Senior Living Campus does have continuous gas flow from the natural gas company. " Facility has acquired an MOU from Xcel Energy " All residents and staff have the potential to be affected if the generator does not have a continuous flow of natural gas in the event of a disaster. " Maintenance staff were re-educated on the importance of obtaining MOUs per regulations for disasters, and to maintain all documentation in a designated binder. Administrator or designee will audit the documentation binder monthly for 6 months to ensure the MOU remains in the binder.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 1, 2025

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: April 24, 2025

Dear Administrator:

On June 9, 2025, the Minnesota Departments 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2025

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: Reinspection Results
Event ID: JQJ812

Dear Administrator:

On June 9, 2025 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 April 24, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112