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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MDHW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**

2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENFIELDS LIVING WITH CARE**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/09/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Pam Pittman, HFE- NE II 01/27/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/27/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/21/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

CMS Certification Number (CCN): 245263

Administrator
Glenfields Living With Care
1805 Hennepin Avenue North
Glencoe, MN 55336

Dear Administrator:

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

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

Effective September 8, 2021 the above facility is certified for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

Administrator
Glenfields Living With Care
1805 Hennepin Avenue North
Glencoe, MN 55336

RE: CCN: 245263
Cycle Start Date: July 22, 2021

Dear Administrator:

On September 30, 2021, we notified you a remedy was imposed. On September 9, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 8, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 22, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 11, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 22, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 8, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MDHW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**
2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/22/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)
13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Judy Loecken HFE - NE II 08/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/15/2021 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 30, 2021

Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

RE: CCN: 245263
Cycle Start Date: July 22, 2021

Dear Administrator:

On August 11, 2021, we informed you that we may impose enforcement remedies.

Compliance with the Life Safety Code (LSC) deficiencies cited on July 22, 2021, has not yet been verified.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 22, 2021. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Adminstrative Contractor (MAC) that the denial of payment for new admissions is effective October 22, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 22, 2021. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 11, 2021

Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

RE: CCN: 245263
Cycle Start Date: July 22, 2021

Dear Administrator:

On July 22, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 October 22, 2021 (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 January 22, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	**1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336**

(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 July 19, 2021 - July 22, 2021, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/19/21-7/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5263024C (MN57557) The following complaints were found to be UNSUBSTANTIATED, and no deficiencies were cited. H5263019C, (MN70689), H5263020C (MN69116), H5423021C (MN67120), H5263022C (MN60278). The facility's plan of correction (POC) will serve	F 000		

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

Electronically Signed | 08/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	**1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow assessment results for self-administration of oral medications when medications were left in 1 of 1 resident's (R54) room. Findings include: R54's quarterly Minimum Data Set (MDS) dated 5/24/21, indicated R54 was able to make herself understood and was able to understand others. R54's vision was adequate and had no cognitive impairment. R54 did not have problems swallowing. R54's diagnosis page, print date 7/22/21, indicated diagnosis included dementia, delusional disorder and age related cognitive decline.	F 554	It is the policy of Glencoe Regional Health that each resident will be free from restraints. A BIMS was completed back on 5/24/21 with a score of 15- Resident cognitively intact. A new self-administration of medication assessment was initiated on 8/13/21 on R54. The findings of the assessment show resident is able to self-administer medications after nurse set-up both in dining room and individual room. Resident was found to be reliable in taking medications after nurse set-up medications. Resident's EMR as well as resident's care plan updated to reflect outcome of evaluation. During the survey, MDH received an old facility policy. Facility implemented an	9/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(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 554	Continued From page 2 R54's assessment for self-administration of medications dated 12/7/16, indicated R54 was safe to self-administer medications after set up by a nurse only in the dining room, "Do Not Leave in Room." Assessment signed by R54 and by registered nurse completing the assessment. R54's care plan with revision date 12/6/19, indicated R54 can self-administer medications after set up by nurse in dining room only. No medications set up in room. On 7/19/21 at 6:18 p.m. a medication cup was noted on the tray table in R54's room with two pills in it. R54 stated the medications were left in her room by the nurse currently working. R54 indicated the current nurse always left medications in her room for her to take. On 7/21/21, at 2:24 p.m. licensed practical nurse (LPN)-A stated she has set up R54's medications and left them with R54 in the dining room, but watched her to ensure she took them. LPN-A stated instructions for self-administration of medication were found at the top of the medication administration record (MAR) under "special instructions", then confirmed instructions for R54 included medications are not supposed to be left in R54's room for self-administration. On 7/22/21, at 11:26 a.m. director of nursing (DON) confirmed instructions at the top of R54's MAR included to not leave medications in R54's room for self-administration. DON stated she expected these instructions were followed. If medications are left for R54 in her room, it could result in missed dose of medications.	F 554	online policy system (MCN) to manage/store all in-house policies and procedures. Most recent policy called “Self-Administration of Medication/Nebulized Medication” did not transfer and upload into policy system. The “Self-Administration of Medication/Nebulized Medication” policy included location if self-administration of medication is appropriate for resident. Policy specifically stated information would be located under “Special instructions” under the resident’s care profile in resident’s individual EMR. Review of current location re-evaluated and determined still appropriate as well as the contents of GlenFields “Self-Administration of Medication/Nebulized Medication” policy and procedure. Policy has since been combined with other medication related policies and is now called “Guidelines for Medication Use in GlenFields” policy and procedure. Nursing personnel, including RNs, LPNs and TMAs were re-educated on the “Guidelines for Medication Use in GlenFields” through huddles on August 19, 2021. The education included revisions made to the facility policy and procedure with emphasis on “Self-Administration of Medications”. Continued monitoring: Director of Nursing (or designee) will conduct Quality Assurance/Quality Improvement audits to ensure compliance regarding self-administration practices are being carried out per facility policy. Audits weekly for four weeks, then monthly for 2	

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F 554	Continued From page 3 Facility policy, Self Administration of Meds revision date 6/1998, did not identify how specific instructions related to self-administration would be communicated.	F 554	months and/or until 100% compliance is achieved. DON will report the results of the audits to the QAPI steering team for review and follow-up action if needed. The DON (or designee) will report the results of the audits to the QAPI steering team for review and follow-up action if needed.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 604		9/3/21

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F 604	Continued From page 4 alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 resident (R34) was free of restraints, when staff locked the wheelchair brakes to keep R34 confined to an area in her wheelchair. Findings include: R34's quarterly Minimum Data Set (MDS) dated 5/6/21, indicated R34 had moderate cognitive impairment and no restraints were used. R34's diagnosis list dated 7/22/21, included dementia, history of falling, cognitive communication deficit. R34's care plan failed to include use of wheelchair brakes as a fall intervention. On 7/19/21 at 6:28 p.m., R34 was seated in her wheelchair in the day room. The back brakes on the wheelchair were locked. The back brakes were out of R34's reach. R34's wheelchair was pushed up to a table with a variety of items placed on it. There were no staff present in the area at the time of this observation. R34 placed her hands against the table and pushed until her wheelchair was tipping back, the front wheels where completely off the floor. When the front wheels were back on the floor, R34 pushed against the table again. The table moved approximately six inches away from R34. On 7/20/21 at 8:46 a.m., R34 was seated in her	F 604	During the survey, R34 was assessed by therapy to determine if wheelchair was still appropriate for resident. Per findings, R34 was provided with a different wheelchair on 7/23/21 that does not have back brakes. R34's care plan was reviewed and updated. GlenFields Living with Care will continue to foster a restraint free home that promotes the minimal use of restraints to enhance resident care and safety. Resident safety devices will be utilized to protect the resident from injury to self and others according to facility policy and procedure. The facility restraint policy was revised to include specific examples of methods or devices that could be considered restraints, for example, "Locking resident's brakes (front or back) on wheelchair if resident unable to unlock at will". Education on "GlenFields Restraint Policy and Procedure" conducted through huddles on August 19, 2021. The education included examples of what could be considered a restraint (i.e. locking resident brakes if resident unable to unlock at will). Retraining will be also conducted with required education modules for all GlenFields employees annually. Continued Monitoring: Director of Nursing	

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F 604	Continued From page 5 wheelchair at the dining room table. The back brakes on her the wheelchair were locked. On 7/20/21 at 9:39 a.m., R34 was still at the dining room table in her wheelchair with the back brakes locked. R34 looked around and stated, "Is someone going to come help me?" as she was attempting to move her wheelchair away from the table, but was unable to. Staff responded by releasing the brakes and moving R34 out of the dining room. On 7/19/21 at 6:39 p.m., nursing assistant (NA)-A stated R34's wheelchair back brakes are always locked to prevent her from moving away from the table. NA-A indicated the back brakes were locked so R34 was not able to release them. On 7/21/21 at 12:53 p.m., NA-B stated they locked R34's wheelchair back brakes when no staff were around because she tries to stand up. On 7/21/21 at 2:17 p.m., licensed practical nurse (LPN)-A stated if a resident was not able to release the wheelchair brakes, then it would be considered a restraint. LPN-A indicated R34 was at risk for falls, R34's fall interventions did not include locking the wheelchair brakes. She is not able to release them, so it would be considered a restraint. On 7/22/21 at 10:03 a.m., registered nurse (RN)-A stated R34 is at risk for falls. RN-A indicated R34's fall interventions did not include locking her wheelchair brakes because it would be considered a restraint because R34 is not able to release the brakes. Locked wheelchair brakes could result in R34 tipping her wheelchair over resulting in an injury.	F 604	(or designee) will conduct Quality Assurance/Quality Improvement audits to ensure compliance regarding facility restraint policy. Audits weekly for four weeks, then monthly for 2 months and/or until 100% compliance is achieved. DON will report the results of the audits to the QAPI steering team for review and follow-up action if needed. The DON (or designee) will report the results of the audits to the QAPI steering team for review and follow-up action if needed.	

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F 604	Continued From page 6 On 7/22/21 at 11:31 a.m., director of nursing (DON) stated the facility was free from use of restraints. If a R34's wheelchair brakes were locked and R34 was not able to release them, then the brakes would be considered a restraint. DON stated the risks of using wheelchair brakes as a restraint included a potential for injury. Facility restraint policy dated 2/4/21, indicated use of restraints required an assessment, reassessment, documentation, communication with family, and the resident's personal physician be updated. The resident's care plan would include information regarding use of the restraint. These requirements were not found in R34's record.	F 604		
F 812 SS=F	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. (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	F 812		9/8/21

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F 812	Continued From page 7 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary conditions in the main kitchen. This practice had the potential to affect all residents, staff and visitors who ate at the facility. Findings include: On 7/19/21, at 12:53 p.m. the initial tour of the kitchen was completed with the dietary director (DD). The following areas of concern were identified. -walk in cooler floor was observed to have food debris and plastic items on the floor. A light fixture hanging from the ceiling in front of fans had approximately one quarter inch layer of black fluffy debris between the inner glass cover and the outer cage. The debris at the bottom of the light fixture was waving in the breeze from the fans. The inner glass cover of the light fixture had an area one inch round of brown substance. - walk in freezer inner side of door was observed to have ice build up on edge of door approximately one quarter inch thick from the top of the door to the bottom. Inner door surface was observed to have thin layer of ice. Plastic slates at entrance observed to have two missing slats, one slat with crack approximately two inches long, one slat was broken off about three inches from the floor, one broken off approximately four inches from the floor and one broken off approximately five inches from the floor. Light fixture at the back of the walk in freezer was observed to have an abject approximately one	F 812	GRH will procure food from sources approved or considered satisfactory by federal, state or local authorities. GRH will also store, prepare, distribute and serve food in accordance with professional standards for food service safety. On 8/16/21 the walk-in cooler and freezer were thoroughly cleaned. Cleaning included, but not limited to the floors, ceiling, light fixtures and condenser fans and shelving. On 8/16/21, the cleaning schedule was revised to increase floor cleaning to 5 days/week. On 8/17/21, The Director of Nutrition Services and the Director of Maintenance met to review the current policy related to safety and sanitation. They revised the policy. Maintenance will clean the light fixtures and fan units every 6 months and as needed. On 8/17/21, The Freezer plastic guards were removed. Replacement of the walk in cooler floor will be complete by December 31, 2021. By September 1, 2021 nutrition services staff and maintenance staff will be educated on the revised policy and new cleaning schedules. The Kitchen Manager (or designee) will conduct quality assurance/quality improvement audits to ensure cleanliness of the cooler/freezer weekly for 6 weeks. Audits will continue monthly for 3 months and/or until 100% compliance is achieved.	

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F 812	Continued From page 8 inch long and a quarter inch wide. On 7/20/21, at 4:20 p.m. walk in cooler was observed to have several small areas of black fuzzy debris on ceiling from the back of the cooler to half way to the door. There was a crevasse that ran from the front of the cooler to the back where the two halves of the ceiling met, the length of the crevasse was observed to have black debris the entire length. Cooler floor continued to have food debris and plastic items on floor. When interviewed on 7/20/21, at 4:25 p.m. cook-A stated the cleaning in the kitchen was done on a schedule with the cooler having one area of shelving cleaned according to a numbered diagram. Cook-A stated that cooler light fixture "looked dirty, it should have been cleaned awhile ago"' "the ceiling looks nasty". Cook-A was unsure of who cleaned the floors, ceiling and light fixtures in the cooler and freezer. During interviewed and observation on 7/22/21, at 8:07 a.m. dietary director (DD) stated kitchen cleaning was completed according to the weekly cleaning schedule. DD stated the schedule is laid out for a different area to be cleaned each day and shift. Day shift sweeps at the end of their shift, evening shift sweeps and mops. Environmental services does deep cleaning monthly, this did not include the walk in cooler or freezer. If the kitchen staff noticed the light fixtures need cleaning they were to notify DD for a work order to be completed as maintenance cleaned light fixtures. Cooler floor continued to have food debris and plastic items on the floor, debris on light fixture and ceiling, walk in freezer continued to have ice build up and debris	F 812	Director of Nutrition Services will report audit results to the QAPI steering team for review and follow up action if needed.	

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F 812	Continued From page 9 remained in light fixture. During interview on 7/22/21, at 10:37 a.m. the administrator stated the expectation was to ensure cleaning was done not only according to the paper schedule but also if staff notice something was not clean they were to clean it or report it. Administrator further stated cleaning of cooler and freezer "was not up to standards" Dietary Cleaning Schedule identified a week schedule and contained 8 columns and 9 rows of boxes, top row identified days of the week with first box blank. first column indicated which kitchen staff member was responsible for cleaning, remaining boxes identified which area of the kitchen was to be cleaned. Schedule identified Wednesdays cooler and freezer were to be swept and mopped. Facility Sanitation Monitoring Standards Nutrition Services policy dated as reviewed 7/2020, indicated food service supervisor and dietetic tech maintained the cleaning schedule, cleaning schedule was posted and reviewed weekly. Environmental services team cleaned and sanitized walls, floor and ceiling annually and as needed. Facility policy and cleaning schedule failed to identify when light fixtures, walk in cooler and walk in freezer wall and ceiling cleaning were scheduled.	F 812		

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	245263	A. BUILDING **02 - GLENCOE REGIONAL HS GLEN FIELDS** B. WING _____	**07/21/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Glencoe Regional Health Services 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 18 New 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		08/19/2021

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

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K 000	Continued From page 1 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. Glencoe Regional Health Services was entirely remodeled in 2019 and will be surveyed as new construction. This is a one-story building with no basement that was built of Type II(111) construction and is fully fire sprinkler protected. The nursing home is separated from a critical access hospital and a senior apartment building by a complying two-hour firewall assembly. The facility has a capacity of 108 beds and had a	K 000		

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K 000	Continued From page 2 census of 92 at the time of the survey. At the time of this survey, the requirements of 42 CFR, Subpart 483.70(a), is NOT MET.	K 000		
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 _____ 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 a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient practice could have a widespread impact on the residents within the facility.	K 353	On 7/26/21, Viking Automatic Sprinkler company performed annual sprinkler testing with no deficiencies noted. The inspection was documented in the GRH Fire Log Book. The GRH maintenance engineers will conduct and document quarterly fire sprinkler inspections. The Director of Maintenance will monitor for compliance.	8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING **02 - GLENCOE REGIONAL HS GLEN FIELDS** B. WING _____	**07/21/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	**1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336**

(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 353	Continued From page 3 FINDINGS INCLUDE: On 07/21/2021, between 10:00 AM and 1:00 PM, it was revealed that there was no documentation available to review to show that the quarterly fire sprinkler test was conducted during the 1st and 2nd quarters of 2021. This deficient practice was verified by the Facility Maintenance Director.	K 353		