Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2025

Administrator
Glenfields Living with Care
2015 Hennepin Avenue North
Glencoe, MN 55336

RE: CCN: 245263
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 September 5, 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 December 5, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFIELDS LIVING WITH CARE	2015 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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E 000	Initial Comments On 6/2/25 to 6/5/25, 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 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 6/2/25 to 6/5/25, 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. : H52635767C (MN00105522). H52635767C/MN 00105522 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2025

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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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		7/26/25

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F 656	Continued From page 2 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan included management and monitoring of anticoagulant (blood thinner) therapy for 2 of 3 residents (R30, R66) reviewed for anticoagulants. Findings include: R30's annual minimum data set (MDS) dated 5/1/25, indicated cognitively intact. R30 had diagnoses of atrial fibrillation (an irregular heart rate that commonly causes poor blood flow), hypertension (high blood pressure), and history of cerebral infarction (stroke). R30's electronic medical record (EMR) included an order for Eliquis (a blood thinner) 5 milligrams (mg) twice a day, with a start date of 7/4/23. However, failed to include an order to monitor for potential side effects or signs ob bleeding due to Eliquis use. R30's care plan last revised 5/20/25, failed to include anticoagulants or to monitor for side effects of the medication. R66's admission MDS dated 2/18/25, indicated severe cognitive impairment. R66 had diagnoses of hypertension (high blood pressure), diabetes, Alzheimer's disease (a condition that affects	F 656	The identified residents receiving anticoagulation therapy without appropriate care plan documentation have had their care plans updated to reflect current anticoagulation use, monitoring parameters, potential side effects, and bleeding precautions. All residents on anticoagulation therapy have the potential to be affected by the alleged deficient practice. A full audit of all current residents receiving anticoagulation therapy was conducted on 6/25/25 to identify any others whose care plans were missing or incomplete in regard to anticoagulation management. All residents on anticoagulation therapy are care planned accordingly. All Charge nurses, RN Care Coordinators and MDS staff members received re-education on care plan requirements specific to anticoagulant use, including risks, monitoring needs, and interventions. The DON or designee will conduct weekly audits of new admits/readmits and/or residents initiated on anticoagulant therapy to ensure appropriate care plan documentation for 4 weeks, then monthly for two months and/or until compliance is	

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F 656	Continued From page 3 memory, thinking, and behavior), and history of cerebral infarction (stroke). R66's order summary report dated 6/5/25, included an order for warfarin sodium 10 milligrams (mg) ever Wednesday and Saturday and warfarin sodium 7.5 mg every Monday, Tuesday, Thursday, Friday and Sunday. Order Summary Report failed to include an order to monitor for potential side effects or signs of bleeding due to warfarin use. R66's undated care plan failed to include he took anticoagulants or to monitor for side effects of the medication. During interview on 6/4/25 at 9:29 a.m., registered nurse (RN) case manager (CM)-C stated nursing would review a resident's medication list to know if anyone was on an anticoagulant. CM-C stated nursing assistants (NA) do not have access to the medication list but should report any signs of bleeding to a nurse because that would be abnormal. During interview on 6/5/25 at 8:53 a.m., consultant pharmacist (CP) stated he reviewed charts during monthly pharmacy reviews to look for any necessary labs and interactions. The CP stated he expected monitoring for bruising and bleeding. The CP also stated it would be important to be aware when someone was on a blood thinner because they would be more prone to bleeding with routine dental care. During interview on 6/5/25 at 9:42 a.m., the director of nursing (DON) stated nursing assistants should monitor for bruising and update nursing when needed. Nursing should watch for	F 656	achieved. 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 656	Continued From page 4 bruising and other side effects of anticoagulants. The DON stated the care plan should include when a resident was on an anticoagulant. Undated facility policy for anticoagulants use failed to address monitoring for anticoagulants.	F 656		
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 interview and document review, the facility failed to update the primary care physician (PCP) with significant weight gain for 1 of 1 residents (R66) reviewed for nutrition. Findings Include: R66's admission Minimum Data Set (MDS) dated 2/18/25, included R66 had severe cognitive impairment. R66 had diagnoses of hypertension (high blood pressure), diabetes, Alzheimer's disease (a condition that affects memory, thinking, and behavior), and obstructive sleep apnea (a collapse or closure of the airway during sleep). R66's weight was recorded at 252 pounds (lbs). According to R66's electronic medical record	F 684	DON sent additional documents to MDH on 6/9/25 (within allotted time to send additional documents) that included a visit note (dated 4/9/25) from the identified resident's (R66) PCP. The visit note included, PCP acknowledging resident's current weight and stated "which is up 9 pounds from 2 months ago". PCP conducted an assessment on resident and noted no concerns regarding the weight increase. RN Care Coordinator spoke with PCP on 6/24/25 and PCP states when PCP speaks with resident's spouse regarding weight, she indicates resident "will eat anything you put in front of him". After PCP ordered labs, Lasix was started. PCP saw resident again on 6/18/25 and stated	7/26/25

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F 684	Continued From page 5 (EMR) on 02/12/2025, R66 weighed 252.0 lbs. On 05/28/2025, R66 weighed 292.0 pounds which was a 15.87 % gain. R66's weight change note dated 2/26/25, included a weight warning that was not likely nutrition related and that the nurse manager was notified to follow up. R66's health status note dated 3/8/25, included R66 had audible wheezing and a 13 lb weight increase since 2/2/25. No update to PCP was noted. R66's weight change note dated 5/8/25, included a weight warning of 288 lbs and that note was likely not nutritionally related. RN was updated for fluid status evaluation. R66's weight change note dated 5/21/25, included a weight warning and that note was likely not nutritionally related. RN was updated for fluid status evaluation. R66's care conference note dated 5/23/25, included weight fluctuations likely fluid related and that RN was notified of weight change. R66's health status note dated 5/24/25, included a respiratory and edema assessment. No update to PCP was noted. During interview on 6/4/25 at 9:33 a.m., registered nurse (RN) case manager (CM)-C stated the registered dietitian (RD) monitored weights and updated nursing with an email when there was a weight gain concern. CM-C stated nursing did a cardiac assessment and updated the provider after the RD noted a weight increase	F 684	resident “does tend to still eat quite a lot and fairly frequently.” PCP related this to a possible medication and reduction of medication ordered at that time. During this visit diuretic was changed. PCP continues to monitor weights/labs with each visit and NP or PCP updated in between as needed by nursing team. The Weight Monitoring Policy/Procedure was revised to include nursing conducting a cardiac evaluation when notified by Dietician of weight gain if not food related to determining if weight gain is medically related. In addition, if concerns are identified, nursing is to notify the resident’s PCP, NP or Hospitalist to address accordingly. Nurses and Dieticians will be educated on the revisions/procedure changes by 7/15/25 via huddles. Audits will be conducted by Dietician on any residents triggered for a significant weight gain for 4 weeks, then monthly for two months and/or until compliance is achieved. Dietician (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 684	Continued From page 6 concern. CM-C confirmed a cardiac assessment was noted on 5/24/25. CM-C confirmed R66 had a 40 lb weight increase since admission and the provider should have been updated with the increase, but was not. During interview on 6/4/25 at 8:06 a.m., RD stated she monitored weights weekly and checked in with nursing and the homemakers to see if they have noticed any changes. The RD stated she depended on them for updates on changes because they were there daily. RD stated she noticed an increase in R66's weight and, after reviewing intakes and rate of increase, she felt it was possibly related to fluid retention. RD stated her process was to send an email to update nursing, along with putting a progress note into the resident's chart. The RD confirmed she sent two email updates, one on 5/8 and one on 5/23 to update nursing on the weight concern. Email from RD to CM-C dated 5/8/25 included R66 had ongoing significant weight gain, with a gain of 13 lbs in 7 days that was not likely related to nutrition. Email from RD to CM-C dated 5/21/25, included R66 had a 24 lb weight gain in the last 30 days and was not likely due to nutrition. Email included a request to monitor fluid status change. During interview on 6/5/25 at 9:48 a.m., the director of nursing (DON) confirmed weights were obtained weekly on bath day unless otherwise ordered by a provider. Weights were monitored by the RD and updated nursing with any increase thought to be medially related. The DON stated she expected nursing to follow up with a cardiac assessment and review of potential reasons for	F 684		

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F 684	Continued From page 7 increase. The DON confirmed a 40 lb weight gain since admission would have been a significant increase and she expected nursing to update the PCP for follow up. The DON stated it was important to update the PCP with weight increase because there may be a medical reason that was not being addressed. Facility policy for weight monitoring dated 2/11/22, included nursing assistants (NA) are to obtain weights on bath days. The NA should review previous weight and if the weight had changed by 3 lbs in a week or 5 lbs in a month, the weight should be rechecked immediately.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 688	On 6/12/25, the identified resident (R8)	7/26/25

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F 688	Continued From page 8 failed to consistently offer range of motion (ROM) and exercises for 1 of 1 residents (R8) reviewed for restorative nursing program. Findings include: R8's admission Minimum Data Set (MDS) dated 6/23/24, included R8 was cognitively intact, able to make self be understood, and able to understand others. R8 had a diagnoses of stage 4 pressure ulcer on her sacral region (a wound caused by pressure extending to underlaying tissue like muscle, bone or tendon), multiple sclerosis (MS)(a disease that can cause weakness, pain, fatigue and impaired coordination), and malnutrition (a lack of proper nutrition). During interview on 6/2/25 at 1:11 p.m., R8 stated she was supposed to get ROM exercises, but staff do not always offer them to her. R8 wanted to complete ROM exercises because she knew it was important to prevent weakness from MS. R8's task documentation for restorative program - exercise orders for dates 5/15/25 to 6/4/25, included 12 "yes" responses, 3 "no" responses, and 26 "not applicable" responses. R8's task documentation for Restorative Program - other for dates 5/6/25 to 6/4/25, included 19 "yes" responses, 2 "no" responses, and 38 "not applicable" responses. R8's task documentation for Restorative Program - ROM for dates 5/6/25 to 6/3/25, included 9 "yes" responses, 4 "no" responses, and 45 "not applicable" responses. Progress notes dated 6/2/25, 5/28/25, 5/19/25, 5/11/25, 5/5/25, 4/27/25, 4/23/25, and 4/17/25, included a summary of restorative activity for the	F 688	was evaluated by Licensed Occupational Therapist and restorative program updated. The DON performed a facility-wide audit of all residents on ROM/Exercise Programs on 6/25/25. Through review of audit completed and discussion with the nursing team, there were a few areas that led to the program breakdown, specifically in household where resident (R8) resides, which is TCU/short stay area. One concern is the unmanageable workload due to the number of restorative programs in this specific household. Most already participate in therapy and residents will at times refuse because they've already worked with therapy. In addition, breakdown in communication between therapy and nursing was identified as well as program accountability. Nursing personnel, including RNs, LPNs, and NARs will be re-educated on restorative care requirements, documentation protocols, and importance of consistency for maintaining resident functional levels by 7/15/25 via huddles. Therapy and nursing to jointly review the restorative programs to reduce redundancy, clarify responsibilities, and make programs more manageable for frontline staff while increase/prevent decrease in residents ROM/Mobility. The DON or designee will monitor the implementation of training by performing random ROM/Exercise program audits for 5 residents weekly x4 weeks, then monthly for 2 months to ensure residents	

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F 688	Continued From page 9 week. Progress notes included a therapy referral would not be submitted due to there being ample opportunities for staff to offer the program. During interview on 6/4/25 at 10:20 a.m., nursing assistant (NA)-A stated ROM exercise were listed on a restorative list and documented in the electronic charting system. NA-A stated a refusal slip needed to be filled out when a resident refused. NA-A stated she documented "not applicable" when the task was not offered or completed on that shift because of not having time. During interview on 6/4/25 at 10:28 a.m., NA-B stated restorative and ROM tasks were documented in the electronic charting system and on restorative papers. NA-B stated she marked "not applicable" when she did not offer the task to the resident. During interview on 6/5/25 at 8:17 a.m., director of therapy (DOT) stated therapy was involved in creating restorative nursing programs. DOT stated she expected an update if the restorative program was not completed as ordered for any reason, including when it was not offered. DOT stated she spoke with R8 recently and R8 stated she wished to continue with the restorative programs as ordered. DOT stated completing the restorative program and ROM exercises was important to prevent decrease in mobility and prevent falls. During interview on 6/5/25 at 9:57 a.m., director of nursing (DON) stated the registered nurse care coordinators monitored the restorative task completion weekly and documented with a progress note. The DON expected follow up with	F 688	on restorative programs are being met according to their individual programs. 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 688	Continued From page 10 the NA team to find out why the task was not completed. DON stated when "not applicable" was charted, it meant the task was not completed on that shift. The DON stated the restorative progress notes indicated the program was not offered. The DON stated the resident was at risk for deconditioning and decline in ability if the program was not being offered and completed. Undated facility policy for repositioning included a restorative program would be designed according to the resident's goals, ability and desires.	F 688		
F 880 SS=E	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		7/26/25

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F 880	Continued From page 11 §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. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 12 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 ensure proper hand hygiene was completed for 2 of 2 residents (R8, R63) observed for wound care and failed to properly implemented enhanced barrier precautions (EBP) for 4 of 4 residents (R8, R63, R66, R73)) reviewed for contact precautions. Findings include: R8's admission Minimum Data Set (MDS) dated 6/23/24, included R8 was cognitively intact, was able to make self be understood and was able to understand others. R8 had a diagnosis of stage 4 pressure ulcer on her sacral region (a wound caused by pressure extending to underlying tissue like muscle, bone or tendon), multiple sclerosis (MS)(a disease that can cause weakness, pain, fatigue and impaired coordination), and malnutrition (a lack of proper nutrition). During observation on 6/4/25 at 10:38 a.m., registered nurse (RN)-A completed wound care on R8. RN-A washed hands with soap and water and applied gown and gloves prior to starting wound care. RN-A removed soiled dressing and cleansed wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A cleansed second wound as ordered. RN-A removed gloves, washed hands with soap and water and applied new gloves. RN-A packed first wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A packed second wound as ordered. RN-A changed gloves but did	F 880	Infection Prevention & Control (Hand hygiene concern during wound care): It is the policy of the facility to 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. It is the policy of this facility to ensure proper hand washing and hand hygiene techniques are being followed at all times as well as following the facility procedure for proper wound care. Both staff members identified during the survey as noncompliant were re-educated on 6/4/25 and on appropriate hand hygiene protocols during wound care. An ICAR assessment of the facility's current process was completed on 6/10/2025 by DON. The findings revealed that nursing personnel were aware of the facility's handwashing/hand hygiene policy as well as infection prevention and control policies and practices intended to facilitate maintaining a safe, sanitary and comfortable environment and help prevent/manage transmission of diseases and infections. Findings also revealed nursing personnel were aware of best practice in relation to hand hygiene during wound care/dressing changes.	

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F 880	Continued From page 13 not complete hand hygiene. RN-A placed a clean dressing as ordered to both wounds. RN-A changed gloves but did not complete hand hygiene. RN-A started wound care on wound to R8's thigh by removing soiled dressing. RN-A changed gloves but did not complete hand hygiene. RN-A cleansed wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A completed wound care to thigh by applying new clean dressing. RN-A completed hand hygiene with soap and water and applied clean gloves prior to completing wound care on ankle wound. RN-A removed soiled dressing and changed gloves without completing hand hygiene. RN-A cleansed wound and completed wound care as ordered. RN-A removed gloves and washed hands with soap and water. During interview on 6/4/25 at 11:23 a.m., RN-A stated hand hygiene should be completed prior to starting wound care, any time you remove a soiled dressing and when wound care is completed. RN-A stated she had been taught to complete hand hygiene every time gloves were changed, but did not feel it was necessary to complete hand hygiene as frequently during wound care and does not complete it every time she changes her gloves. RN-A stated changing gloves was not a substitute for hand hygiene. R63's admission MDS dated 4/20/25, included R63 had an admission date of 4/14/25. R63 was cognitively intact and had diagnoses of diabetes with skin complications, peripheral vascular disease (a condition that narrows blood vessels and reduces blood flow to limbs), multidrug-resistant organism (MDRO), and a surgical wound without normal wound healing.	F 880	A full review of infection control surveillance logs from the past 30 days (Date completed 6/10/25) was completed. No infection trends suggestive of widespread hand hygiene noncompliance with wound care/skin related infections were found. Facility policy on hand hygiene was reviewed, and no changes were required. The policy was provided to surveyors on 6/2/25. Policy includes that hand hygiene is to be conducted before moving from work on a soiled body site to a clean site and after removal of gloves-even if new gloves will be worn. Nursing personnel, including RNs and LPNs will be re-educated on the facility hand hygiene policy, specifically the expectation/practice during wound care and removal of gloves and when applying new gloves. Education will be provided by 7/15/2025 via huddles. The DON or designee will monitor 5 nursing staff personnel (dependent on resident audit pool) weekly times four weeks for compliance with handwashing/hand hygiene during wound care/dressing changes, then monthly for two months and/or until compliance is achieved. DON (or designee) will report the results of the audits to the QAPI steering team for review and follow-up action if needed. Any failure to comply will result in progressive disciplinary action, starting with verbal counseling and	

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F 880	Continued From page 14 During observation on 6/4/25 at 10:00 a.m., RN-B completed wound care for R63. RN-B completed hand hygiene, applied gown and gloves prior to starting wound care. RN-B removed soiled dressing and changed gloves. RN-B did not complete hand hygiene. RN-B cleansed wound as ordered. RN-B did not complete hand hygiene or change gloves. RN-B completed wound care and completed hand hygiene upon completion. During interview on 6/4/25 at 12:15 p.m., RN-B stated she completes hand hygiene prior to starting wound care and after completion of wound care. RN-B stated she would not wash her hands at any other time, except if she was moving from one wound to another. During interview on 6/4/25 at 11:29 a.m., charge nurse RN-C stated the expectation was for staff to wash hands with soap and water prior to starting wound care and upon completion. Hand sanitizer could be utilized with glove changes and when going from dirty to clean tasks. During interview on 6/4/25 at 11:38 a.m., director of nursing (DON) stated hand hygiene was expected prior to starting wound care and when hands are visibly soiled. The DON stated she expected hand hygiene to be completed any time gloves were changed even if hands were not visibly soiled. Facility policy for hand hygiene requested and not provided. Facility document for infection prevention included to perform hand hygiene immediately after removal of gloves. EBP:	F 880	documented retraining. Enhanced Barrier Precautions: Residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) will be placed on EBP. Residents who have a history of CDC targeted MDRO infection will be considered colonized per CDC guidance. These residents will remain on EBP. Residents with indwelling medical devices or wounds but who do not have a history of CDC targeted MDRO infection, who refuse EBP will receive education on the reason for EBP, the risks for refusal and the benefits of keeping EBP in place. If these residents continue to refuse EBP, EBP will be removed per the resident's right to choose and the education will be documented. In addition, the facility will review the risks/benefits and provide education quarterly when a resident refuses EBP.	

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F 880	Continued From page 15 R8's admission Minimum Data Set (MDS) dated 6/23/24, included R8 was cognitively intact, was able to make self be understood and was able to understand others. R8 had a diagnosis of stage 4 pressure ulcer on her sacral region (a wound caused by pressure extending to underlying tissue like muscle, bone or tendon), multiple sclerosis (MS)(a disease that can cause weakness, pain, fatigue and impaired coordination), and malnutrition (a lack of proper nutrition). During interview and observation on 6/2/25 at 1:14 p.m., R8 stated she had multiple wounds that staff completed daily wound care on. R8's room did not have any signage indicating R8 should be on precautions or storage for personal protective equipment (PPE) visible. Facility document titled Negotiated Risk Agreement and Release signed 4/10/25, included R8 had a Foley catheter, ostomy, and open wounds and EBP was recommended with high-contact resident care per Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take. During interview on 6/3/25 at 10:55 a.m., R8 stated she did remember the facility discussing the form with her, but felt it was presented as information and not as an option she could choose. R8 confirmed the staff do not wear a gown when working with her catheter, only gloves.	F 880		

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F 880	Continued From page 16 R63's admission MDS dated 4/20/25, included R63 had an admission date of 4/14/25. R63 was cognitively intact and had diagnoses of diabetes with skin complications, peripheral vascular disease (a condition that narrows blood vessels and reduces blood flow to limbs), multidrug-resistant organism (MDRO), and a surgical wound without normal wound healing. During interview and observation on 6/2/25 at 6:37 p.m., R63 stated she had a diabetic ulcer on her foot and had wound care completed by staff. R63's room did not have any signage indicating R63 should be on precautions or storage for PPE. Facility document titled Negotiated Risk Agreement and Release signed 4/14/25, included R63 had a diabetic foot wound and EBP was recommended with high-contact resident care per CDC and CMS guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take. During interview on 6/3/25 at 10:28 a.m., R63 stated she did not remember reviewing the form and did not remember signing it. R63 confirmed she was admitted on 4/14/25 and recalled signing a lot of paperwork that day. R66's admission Minimum Data Set (MDS) dated 2/18/25, included R66 had severe cognitive impairment. R66 had diagnoses of hypertension (high blood pressure), diabetes, Alzheimer's disease (a condition that affects memory, thinking, and behavior), and benign prostatic hyperplasia (enlargement of the prostate gland which can cause difficulty with urination). During interview and observation on 6/2/25 at	F 880		

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F 880	Continued From page 17 4:21 p.m., FM-B confirmed R66 had a urinary catheter. R66's room did not have any signage indicating R66 should be on precautions or storage for PPE. Facility document titled Negotiated Risk Agreement and Release signed 2/12/25, included R66 had an indwelling Foley catheter and EBP was recommended with high-contact resident care per CDC and CMS guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take. During interview on 6/3/25 at 11:48 a.m., FM-B stated she did not remember reviewing the consent. FM-B stated she did not remember the facility discussing care of his catheter or risks. R73's quarterly MDS dated 4/7/25, included R73 was rarely or never able to make self be understood and sometimes able to understand. R73 had diagnoses of dysphagia (difficulty swallowing) and had a gastronomy tube (g-tube) (a device that delivers nutrition directly to the stomach or small intestine). During interview and observation on 6/2/25 at 2:01 p.m., family member (FM)-A confirmed R73 had a feeding tube. R73's room did not have any signage indicating R73 should be on precautions or storage for PPE. Facility document titled Negotiated Risk Agreement and Release signed 10/1/24, included R73 had a g-tube and EBP was recommended with high-contact resident care per CDC and CMS guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility	F 880		

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F 880	Continued From page 18 would take. During interview on 6/3/25 at 11:32 a.m., FM-A stated she did not recall being educated on precautions for R73's g-tube nor signing a consent form to waive EBP. Undated facility provided document titled Enhanced Barrier Precautions (EBP) Lists included 20 residents. All 20 residents had "yes" under the column indicating they signed a negotiated risk agreement. During interview on 6/4/25 at 1:01 p.m., DON confirmed the facility had identified 20 residents who qualified for EBP and all 20 had signed a negotiated risk agreement to opt-out of EBP. The DON stated it was the goal of the facility to provide a homelike environment and all of the residents who signed the form understood the risks. Conditions were reviewed at admission and periodically to ensure the facility was providing the necessary precautions. The DON confirmed the EBP negotiated risk form was not reviewed with residents who did not qualify for EBP. During interview on 6/5/25 at 10:06 a.m., DON stated she was unsure how the EBP negotiated risk form was presented to residents, but everything on the form should be explained to the resident and their family. The DON stated there was a lot of information presented during admission and it would be hard to remember every piece of information presented. Undated facility policy for enhanced barrier precautions, included an EBP risk assessment would be completed on all new admission and as	F 880		

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F 880	Continued From page 19 needed to determine if EBP was recommended. If a resident decline or refuses EBP, a negotiated risk agreement would be signed by the resident or representative.	F 880		

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GLENFIELDS LIVING WITH CARE	**2015 HENNEPIN AVENUE NORTH GLENCOE, MN 55336**

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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 06/03/2025. At the time of this survey, Glenfields Living With Care 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 | 06/25/2025

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.

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 _____	**06/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Glenfields Living With Care The facility has a capacity of 108 beds and had a census of 87 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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K 355	Continued From page 2	K 355		
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 and staff interview, the facility failed to install and provide fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 18.3.2.5.3.(8) 18.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 06/03/2025 at 11:05 AM, it was revealed by observation that there was not a class K fire extinguisher installed in the Meadow Ridge kitchen. 2. On 06/03/2025 at 11:15 AM, it was revealed by observation that there was not a class K fire extinguisher installed in the Fairwinds kitchen An interview with the Facility Director, Maintenance Engineer, and Chief Senior Services Officer verified this deficient finding at the time of discovery.	K 355	On 6/3/2025 during our Healthcare Fire Inspection, no Class K fire extinguishers were installed in Meadow Ridge and FairWinds kitchens. 1. Install a Class K fire extinguisher in both Meadow Ridge and FairWinds kitchens. 2. At any new construction and/or remodel of kitchens, we will ensure that a Class K fire extinguisher is installed when needed. 3. Will check the fire extinguishers monthly and will have them checked and replaced if needed at our annual fire extinguishers inspection. 4. The Maintenance/Facilities departments will be responsible to check them monthly and ensure they are included in the annual inspection. Maintenance/Facilities will also ensure that during future construction/remodel projects, a Class K fire extinguisher will be installed when needed. 5. Installed by 7/16/2025.	7/16/25
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		6/3/25

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K 363	Continued From page 3 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 18.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/03/2025 at 11:08 AM, it was revealed by observation the door to room E141 was propped open with a rubber wedge.	K 363	On 6/3/2025 during our Healthcare Fire Inspection, it was observed that doors to rooms E141 and C120 were propped open with a rubber wedge. 1. Removed the rubber wedges the same day, 6/3/2025. 2. Maintenance will remove any/all door wedges when seen. 3. As Maintenance is about the facility, if a door wedge is observed, they will remove it. 4. Maintenance and GRH staff are to monitor that door wedges are not in use.	

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K 363	Continued From page 4 2. On 06/03/2025 at 11:12 AM, it was revealed by observation that the door to room C120 was propped open with a rubber wedge. An interview with the Facility Director, Maintenance Engineer, and Chief Senior Services Officer verified this deficient finding at the time of discovery.	K 363	5. All noted and seen wedges were removed 6/3/2025.	
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. 18.7.1.4 through 18.7.1.7 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 18.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/25 between 10:36 AM, it was revealed by a review of available documentation that the first and second shift fire drills were not completed at varied times.	K 712	On 6/3/2025 during our Healthcare Fire Inspection, it was revealed during documentation that first and second shift fire drills were not completed at varied times. 1. Will include a time frame window for each fire drill on each shift in the work order system for the monthly fire drill task to ensure varied times. 2. The work order for the fire drills will include varied dates and times. 3. Completing the fire drill work orders according to the date and time frame	8/1/25

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K 712	Continued From page 5 An interview with the Facility Director, Maintenance Engineer, and Chief Senior Services Officer verified this deficient finding at the time of discovery.	K 712	windows. 4. Maintenance/Facilities is responsible for the corrective actions and monitoring of the compliance. 5. The above measures of the remedy will be implemented with the fire drills moving forward by 8/1/2025.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 2, 2025

Administrator
GLENFIELDS LIVING WITH CARE
2015 HENNEPIN AVENUE NORTH
GLENCOE, MN 55336

RE: CCN: 245263

Cycle Start Date: June 5, 2025

Dear Administrator:

On August 8, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us