



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 17, 2025

Administrator
Glenoaks Senior Living Campus
100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

RE: CCN: 245360

Cycle Start Date: September 12, 2025

Dear Administrator:

On October 20, 2025, we notified you a remedy was imposed. On November 12, 2025 the Minnesota Departments of Health 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 October 20, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 14, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 20, 2025, 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 20, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 20, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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



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December 17, 2025

Administrator

Glenoaks Senior Living Campus

100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

Re: Reinspection Results
Event ID: 1D66B5-H2

Dear Administrator:

On November 12, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 12, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 20, 2025

Administrator

Glenoaks Senior Living Campus
100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

RE: CCN: 245360

Cycle Start Date: September 12, 2025

Dear Administrator:

On September 12, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 14, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 14, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 14, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 14, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, [Facility Name()] will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 14, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

DEPARTMENT CONTACT

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

**Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

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
202-795-7490

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 at (312) 353-1502.

Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245360		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2025	
NAME OF PROVIDER OR SUPPLIER Glenoaks Senior Living Campus				STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE , NEW LONDON, Minnesota, 56273			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS On 9/10/25 through 9/12/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53603260C (2603730) with deficiencies cited at F550, F609, F610, F689, and F730. 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 that substantial compliance with the regulations has been attained.		F0000			10/20/2025	
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to		F0550	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks does promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. The Administrator met with the 4 residents to investigate the complaints and ensure the residents' immediate emotional and psychosocial needs were met. The staff member involved was immediately suspended pending investigation and ultimately terminated. All residents have the potential to be affected. The Administrator interviewed other residents who received care from the same staff member to ensure there were no		10/20/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0550 SS = E	Continued from page 1 quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview the facility failed to ensure 4 of 4 (R1, R5, R6 and R7) residents were treated with dignity and respect when care was provided to them by nursing assistant (NA)-P Findings include: Review of facility grievances identified a grievance dated 9/5/25, against NA-P made by R1, filled out by the director of nursing (DON). The grievance stated while DON was checking in on R1, R1 reported a nursing assistant for doing cares "too fast." R1 identified NA-P. R1 further stated NA-P needed to slow down and "I don't want her to help if that was even possible." DON reassured R1 she would speak to NA-P and R1 changed the topic. R1's significant Minimum Data Set (MDS) dated 8/24/25, identified no cognition deficits. R1 had history of falls, and diagnoses of fractured hip, chronic obstructive pulmonary disease (COPD), dependent on oxygen and dependent on staff to perform activities of daily living (ADLs) and used a wheelchair. R1 had verbal behaviors and rejection of cares.	F0550	Continued from page 1 other dignity or respect concerns. No additional issues were identified. All staff received mandatory re-education on Abuse, Neglect, and Exploitation, along with dignity and respect in the MN Nursing Home Bill of Resident Rights. The Administer or designee will complete 3 random resident interviews weekly for 4 weeks, then monthly for 2 months, ensuring residents are treated with dignity and respect. Results of audits will be reviewed monthly at the QAPI meeting to monitor for sustained compliance.	

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F0550 SS = E	Continued from page 2 During an interview on 9/11/25 at 11:37 a.m., R1 identified NA-P to surveyor and stated when she knew NA-P was to assist her with cares, it increased her anxiety and caused her to act out. R1 further stated R1 made her feel worthless, during a subsequent interview on 9/11/25 at 2:07 p.m. R5's social service data collection tool dated 7/29/25, identified no cognitive deficits. R5 did not have any behaviors or rejection of cares. During an interview on 9/12/25 at 9:30 a.m., R5 stated NA-P could be rough during cares. Would prefer NA-P not work with her. During a subsequent interview on 9/12/25 at 1:45 p.m., R5 stated NA-P made her feel on edge, more anxious. R6's social service data collection tool dated 8/26/25, identified no cognition deficits, had no behaviors or rejection of cares. R6's face sheet date 9/12/25, indicated diagnoses of cerebral aneurysm, adjustment disorder with depressed mood, and history of cerebral infarct (stroke). During an interview on 9/11/25 at 3:00 p.m., R6 stated if NA-P was working on her hall and she had a request or need, she would wait until the next shift. During a subsequent interview on 9/12/25 at 12:30 p.m., R6 stated NA-P would say totally inappropriate things and then laugh trying to make up for whatever NA-P had said, increasing R6's frustration. R6 further described NA-P as being loud and obnoxious. R65 stated she had reported NA-P but to management, but nothing ever gets done. R7's social services MDS data collection tool dated 7/17/25, identified moderately impaired cognition, and had no behaviors or rejection of cares. R7's face sheet dated 9/12/25, indicated diagnoses of chronic obstructive pulmonary disease (COPD), generalized anxiety, and rheumatoid arthritis. During an interview on 9/11/25 at 2:27 p.m., R7 did not know staff names, however, gave a detailed description was consistent with NA-P. R7 stated NA-P was rough with cares and this upset her but what was she to do, she needed two staff for cares. R7 further stated during a subsequent interview on 9/12/25 at 12:35 p.m., stated she did not want NA-P to come back to work with her and just described her cares as "rough." During an interview on 9/11/25 at 1:03 p.m., NA-G		F0550				

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F0550 SS = E	Continued from page 3 stated she had witnessed NA-P on different dates talking back to R1. NA-P seemed to enjoy upsetting R1 and other resident to see if NA-P could get a reaction from them. NA-G had reported this to the DON. NA-G had not noticed a change with NA-P's behavior with residents. During an interview on 9/11/25 at 3:32 p.m., assistant director of nursing (ADON)-A described NA-P demure as "lacking a bed side manner" but was meeting the needs of the residents appropriately. Further stated NA-P had not had any rough cares. When the NA-P's written warning was brought up ADON-A would not count "rushed and harsh" as rough cares. During an interview on 9/12/25 at 7:40 a.m., DON stated she had gone over the grievance form with NA-P on 9/5/25, and asked NA-P slowed down and encouraged NA-P to treat residents as individuals and had individual care needs and to provide quality care to all residents. Review of NA-P employee files included: -a coaching/teachable moment dated 7/18/25, for her tone of voice and disrespectful and condescending to coworkers. - a written warning dated 8/1/25, NA-P being "harsh" and "rushed", staff have complained about tone and verbiage coming from NA-P that was demeaning and lacked appropriate bedside manner. - a grievance 9/5/25, DON wrote for R1, where R1 identified NA-P by name and reported NA-P was too fast during cares and that it was possible would not like NA-P to assist with cares if possible. Review of facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7/8/24 indicated the following: -Personal degradation of a dependent adult, means a will act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person. -Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Mental abuse includes			F0550			

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

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F0550 SS = E	Continued from page 4 agitating a resident to solicit a response, derogatory statement directed to the resident.	F0550		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse timely to the State Agency for 1 of 1 resident (R1) who reported staff to resident physical abuse. Findings include: A facility five-day investigation submitted by the administrator to the State Agency on 9/3/25 indicated on 8/28/25, R1 had clinic appointment and had become upset with the physician. The report included a statement R1 made to the physician "then we should talk about Glen Oaks and the staff that is beating me up". In review of facility reported incidents to the State Agency there was no indication R1's allegations of abuse were	F0609	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks does ensure that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately (but no later than 2 hours if abuse involving serious bodily injury, and no later than 24 hours otherwise) to the State Agency. Administrator immediately submitted the reports to the State Agency upon discovery of the allegations and conducted investigations. All residents have the potential to be affected. The Administrator and DON reviewed all incident and grievance logs from the previous 30 days to ensure no other allegations were unreported or reported late. No additional reporting issues were identified. All staff received mandatory re-education on Abuse, Neglect, and Exploitation. The Administrator or DON will audit 100% of incident reports/grievances weekly for 1 month, 3 random audits per month will be conducted for 3 months to verify timely reporting. Results of audits will be reviewed monthly at the QAPI meeting to monitor for sustained compliance.	10/20/2025

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F0609 SS = D	Continued from page 5 reported to the State Agency. R1's significant Minimum Data Set (MDS) dated 8/24/25, indicated R1 did not have cognitive impairment. R1 had verbal behaviors and rejection of cares. During an interview on 9/11/25, at 10:17 a.m., Administrator confirmed she submitted the five-day report to the State Agency that included the allegation of abuse R1 had made. On 8/28/25, she was told by the facility scheduler (SCH)-A who heard R1 make the allegation to the physician during her appointment on 8/28/25. The Administrator indicated when she had talked with R1 she was not able to provide specific details of the incident including who the staff member involved and was not willing to further discuss the incident and therefor did not consider the incident reportable. During an interview on 9/12/25 at 7:40 a.m., director of nursing (DON) stated was made aware of incident on 9/5/25 when R1 made a grievance towards NA-P. DON filled out the grievance form and talked with NA-P. DON did not make a report to the SA, regarding the allegation of rough cares as she did not consider rough cares as a reportable event. Review of facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7/8/24 indicated the following: Reporting: -All allegation of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation of property should be reported immediately to the administrator. -All allegations of resident abuse shall be reported to the appropriate state entity not later than two hours after the allegation is made.	F0609		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F0610	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks does ensure that thorough investigations are completed following all allegations of abuse, neglect or exploitation by staff to residents. The Administrator immediately conducted a thorough investigation and submitted reports to the State	10/20/2025

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F0610 SS = E	Continued from page 6 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a thorough investigation was completed and protect residents after 2 of 2 allegations which included rushed and harsh cares in addition to physical abuse were reported by unknown residents which effected (R1, R4, R6, and R7) who reported on going inappropriate behavior and treatment by nursing assistant (NA)-P. Findings include: Review of NA-P's employee record included a written warning dated 8/1/25, that was authored by assistant director of nursing (ADON)-A. The ADON wrote- residents complained of nursing assistant (NA)-P being "harsh" and "rushed", staff have complained about tone and verbiage coming from NA-P that is demeaning and lacked appropriate bedside manner. NA-P's employee record nor did the disciplinary action document identify which residents were involved that led to NA-P's written warning. Further, there were no recorded grievances and/or documentation of the concerns voiced by residents, there was no indication of an investigation into the concerns, or evident that follow-up with the effected residents was completed. During an interview on 9/11/25 at 3:32 a.m. ADON-A described NA-P's demeanor as "lacking a bed side manner" but was meeting the needs of the residents. ADON reviewed the written warning and explained she would not consider the description of "rushed and harsh" as rough cares, however, did not investigate the allegations because she did not think NA-P's rushed and harsh demeanor would be considered abuse. R1's significant Minimum Data Set (MDS) dated 8/24/25, R1 did not have cognitive impairment. R1 had history of falls, and diagnoses of fractured hip, chronic	F0610	Continued from page 6 Agency. The staff member involved was immediately suspended pending investigation and ultimately terminated. Care plans of the 4 residents were updated to address "vulnerabilities of abuse". All residents have the potential to be affected. The Administrator interviewed other residents who received care from the same staff member to ensure there were no other dignity or respect concerns. No additional issues were identified. The following corrective measures were implemented to ensure all future investigations are thorough, timely, and protective of residents: re-education on abuse reporting, resident dignity, and proper care approaches. Recognizing and immediately reporting any allegation of rough, harsh, or disrespectful care. The DON or designee will conduct weekly audits for 4 weeks, then monthly for 3 months, of any new incident or complaint investigation to ensure a thorough investigation is completed and residents are protected.	

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F0610 SS = E	Continued from page 7 obstructive pulmonary disease (COPD), dependent on oxygen and dependent on staff to perform activities of daily living (ADLs) and used a wheelchair. R1 had verbal behaviors and rejection of cares. R1's 7/7/25 did not identify R1's vulnerabilities to abuse, was dependent on staff for activities of daily living involving transfers and toileting and had the risk for or had the potential of altered mood and behaviors. During an interview on 9/11/25 at 11:37 a.m., R1 stated she was very familiar with NA-P. R1 explained NA-P was very rough during cares. When NA-P rolled her in bed she would push really hard on her broken hip and move too fast which caused her increased pain. When R1 would tell NA-P she was hurting her by the way she was moving her, it seemed like NA-P would "just push harder". R1 stated when she thinks about NA-P and when NA-P helps her with cares, her anxiety increased and caused her to "act out". R1 had reported to ADON-A how NA-P treats her however, nothing changed. During a subsequent interview on 9/11/25 at 2:07 p.m., R1 stated the way NA-P treats her made her feel worthless and would prefer NA-P not come into her room. During an interview on 9/10/25 at 1:40 p.m., scheduler (SCH)-A stated she was with R1 at the clinic appointment on 8/28/25 when R1 made an accusation about staff was abusing her, by throwing R1 around. R1 did not tell SCH-A who that staff person was. When SCH-A got back to the facility she reported R1's allegations to the administrator. A facility five-day investigation of R1's fall from a wheelchair van lift submitted by the administrator to the State Agency (SA) on 9/3/25 indicated on 8/28/25, R1 had clinic appointment and had become upset with the physician. The report included a statement R1 made to the physician "then we should talk about Glen Oaks and the staff that is beating me up". In review of investigatory file and facility reported incidents to the State Agency there was no indication any allegations of abuse were investigated after R1 made her statement. A handwritten grievance dated 9/5/25, authored by the director of nursing (DON) on behalf of R1 indicated NA-P was too fast during cares and did not want NA-P to assist her if possible. Facility records did not include any documentation of investigation activities such as interviewing other residents or staff members. During an interview on 9/11/25, at 10:17 a.m.,			F0610			

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F0610 SS = E	Continued from page 8 Administrator confirmed she submitted the five-day report to the State Agency that included the allegation of abuse R1 had made. On 8/28/25, she was told by the facility scheduler (SCH)-A who heard R1 make the allegation to the physician during her appointment on 8/28/25. The Administrator indicated when she had talked with R1 she was not able to provide specific details of the incident including who the staff member involved and was not willing to further discuss the incident and therefor did not consider the incident reportable. Furthermore, Administer denied knowledge of NA-P's written warning 8/1/25, or grievance of 9/5/25. During an interview on 9/12/25 at 7:40 a.m., director of nursing (DON) stated she was made aware of incident on 9/5/25, while she was talking with R1. R1 stated NA-P was "too fast with cares" and asked DON to file a grievance against NA-P. DON filled out the grievance form and talked with NA-P on 9/5/25. DON did not complete an investigation and not talk to other residents about the care NA-P provided. However, DON provided education to NA-P to slow down during cares, every resident has different needs, and residents deserved quality of care. R4's social services data collection tool dated 8/5/25, R1 had no cognitive deficit and had no behaviors or rejection of cares noted. R4's face sheet dated 9/12/25, indicated diagnoses of cerebral infarction (stroke), bipolar disorder, and rheumatoid arthritis. R4 needed assistance with personal care. R4's care plan did not address the vulnerabilities to abuse. During an interview on 9/11/25 at 2:37 p.m., R4 did not know names of staff, however, gave a detailed description that was consistent with NA-P. R4 stated when NA-P gave her a shower she felt like she was rushed. NA-P would scrub with a washcloth really hard in her vaginal area and back which caused her to hurt after the shower. R4 stated she did not want NA-P to bath her because she did not want to have that discomfort and would refuse her shower if NA-P was working. R6's face sheet date 9/12/25, included diagnoses of cerebral aneurysm, adjustment disorder with depressed mood, and history of cerebral infarct (stroke). R6's social service data collection tool dated 8/26/25, indicated intact cognition, had no behaviors or		F0610				

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F0610 SS = E	Continued from page 9 rejection of cares noted R6's care plan did not address the vulnerabilities to abuse. During an interview on 9/11/25 at 3:00 p.m., R6 stated if NA-P was working on her hall and she had a request or need, she would wait until the next shift. During a subsequent interview on 9/12/25 at 12:30 p.m., R6 stated NA-P frustrated and made her very angry because of the way she treated residents. NA-P would make condescending remarks and say inappropriate things but then laugh about it like it was OK or to try to make up for saying them. R6 could not remember specific examples, however it made her feel angry enough "she wanted to punch her or punch something." R7's face sheet dated 9/12/25, indicated diagnoses of chronic obstructive pulmonary disease (COPD), generalized anxiety, and rheumatoid arthritis. R7's social services MDS data collection tool dated 7/17/25, indicated moderate impaired cognition, and had no behaviors or rejection of cares. R7's care plan did not address the vulnerabilities to abuse. During an interview on 9/11/25 at 2:27 p.m., R7 did not know staff names, however, gave a detailed description that was consistent with NA-P. R7 stated NA-P was rough with cares and this upset her but "what was she to do? She needed two staff for cares" and didn't have a choice in the matter. During a subsequent interview on 9/12/25 at 12:35 p.m., R7 stated she did not want NA-P to come back to work with her room and did not give any other information. During an interview on 9/11/25 at 1:03 p.m., NA-G stated NA-P liked to "rile up". When R1 would put on her call light she would taunt R1 by standing in her doorway and say to R1 "you don't want me in there so you have to wait". NA-G stated she had reported these interactions and her concerns to the DON. To her awareness the DON had directed NA-P not to go into R1's room to assist her. Review of facility schedule 8/1/25 through 9/11/25, identified NA-P remained working with all residents of facility till state agency brought allegations to the attention of the administrator on 9/11/25 at 10:17 a.m. Facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy		F0610				

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F0610 SS = E	Continued from page 10 dated 7/8/24 indicated the following: Should an incident or suspected incident or resident abuse be reported or observed, the Administrator must be notified immediately. The administrator will complete documentation of allegation of resident abuse and collect any supporting documents relative to the alleged incident. -Review documentation in resident record. -Assess the resident for injury if the allegation involves physical or sexual abuse. -provide proper notification of primary care provider, responsible party, etc. -attempt to obtain witness statements (oral and/or written) form all known witnesses. -If there is physical evidence that can be preserved, attempt to do so, maintain in a safe location to minimize risk of evidence being tampered with. Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this allegation of abuse is by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following process or a combination of the following, if practicable:1) suspending the employee; 2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility.		F0610				
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.		F0689	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks does ensure that staff follow manufacturer's safety guidelines while operating the wheelchair lift. The wheelchair lift was immediately taken out of service pending inspection and review of safety protocols. The manufacturer's operating manual and safety instructions were obtained and reviewed.		10/20/2025	

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F0689 SS = G	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to follow manufacturer's safety guidelines for operating a wheelchair lift for 1 of 1 resident (R1). The facilities failures resulted in actual harm when R1 fell to the ground and sustained a head laceration that required transfer to the hospital emergency department for treatment. Findings include: Facility reported incident (FRI) #361588 submitted on 8/28/25, identified on 8/28/25, R1 experienced a fall from the facility transport bus while being transferred via the wheelchair lift. The incident occurred at approximately 11:30 a.m. during a scheduled clinic visit. R1 was being loaded onto the bus by trained staff (scheduler (SCH)-A). R1's significant change Minimum Data Set (MDS) dated 8/24/25, indicated R1 did not have cognitive impairment, had diagnoses of fractured hip, chronic obstructive pulmonary disease (COPD), R1 was dependent on staff for activities of daily living (ADLs), had a history of falls, and used oxygen. R1 had verbal behaviors and rejected cares. R1 was dependent on staff for self-care and indoor mobility, used manual wheelchair, and had impairment on one lower extremity. R1's mobility and transfer care plan dated 7/9/25, indicated R1 had a self-care deficit as evidenced by R1 requiring assistance with ADLs, impaired balance during transfers and/or walking. The following interventions were included: -R1 used a wheelchair and required staff to propel it -R1 requires assist of 1 with bed mobility -R1 required assist of two staff for toileting -R1 requires assist of two staff for transfers R1's mood and behavior care plans dated 7/9/25, did not identify target behaviors that R1 had displayed and/or had a history of. The care plan included focus for behavior which identified "alteration and at risk for negative statements, repetitive questions, verbalizations, persistent anger with staff or others, self-depreciation, expressions of unrealistic fears, sadness, crying, repetitive movements, withdrawn/reduced socialization related to diagnoses of	F0689	Continued from page 11 All residents have the potential to be affected. The wheelchair lift was inspected by the maintenance department and verified to be in safe working condition before returning to use. Staff involved in the incident were retrained immediately on the safe and proper operation of the wheelchair lift before resuming its use. The facility's "Fleet Safety Policy" was reviewed and updated to include: resident safety for behavioral issues and trouble shooting. A seat belt and harness designed to attach securely to the wheelchair were purchased to enhance safety during wheelchair lift operation. The DON or designee will observe at least 1 transfer per week for 1 month, and 1 transfer per month for 3 months, verifying the correct use of lift procedures and safety belt and harness use. Results of audits will be reviewed monthly at the QAPI meeting to monitor for sustained compliance.	

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F0689 SS = G	Continued from page 12 depression.” The care plan also had the focus of R1 had a potential for “psycho-social well-being deficit and is at risk for changes in appetite, sleep patterns, ADL’s, mood, socialization and increased sensitivity to environment,” An additional focus included R1 had the potential for “episodes of alteration in mood as evidenced by restlessness, easily fatigued, being irritable, having headaches/stomachaches, excessive worrying or difficulty controlling feelings of worry and having trouble falling asleep and/or staying asleep related to diagnosis of anxiety.” R1’s progress note dated 8/28/25 at 3:33 p.m., indicated R1 went to the emergency department after a fall while be loaded into the facility bus. R1 returned to Glen Oaks with no changes to medications. R1’s progress note dated 8/29/25 at 8:31 p.m., described the fall incident that occurred on 8/28/25 at 11:20 a.m. The note identified, R1 was taken to a doctor appointment by staff trained to operate the facility bus and passed driver assessment. They arrived at clinic at 10:25 a.m. and were taken to exam room. Medical doctor (MD)-A and R1 had a heated discussion over her antianxiety and opioid medications. MD-A ended the appointment with the mention of R1 returning to hospice to help manager her anxiety and pain. SCH-A took R1 to the bus and was loading R1 backwards onto the ramp, locked the brakes, was standing on the ramp and holding R1’s wheelchair while raising the ramp. Ramp stopped moving about six inches from the ground. SCH-A was looking for what stopped the ramp and stepped off ramp. SCH-A first checked right brake to make sure was on. SCH-A stepped off the ramp and R1 fell forward off her wheelchair hitting her head on the ground first. Staff went to get help, then attended to R1’s bleeding head. Front wheels of wheelchair were off the yellow foot stop by three inches, brakes on all the way both sides. R1 obtained a four-centimeter laceration to right forehead as well as a hematoma directly right of eye in temporal area. R1 reported throbbing pain to head and denied pain anywhere else. R1’s Medical and Transport/Emergency Documentation Form dated 8/28/25, that was handwritten included, “11:20 fell in parking lot out of w/c [wheelchair] to pavement.” Right forehead laceration. R1’s hospital emergency department after visit summary (AVS) dated 8/28/25 identified R1 was evaluated for a fall with injury; laceration to forehead. The AVS identified R1 had stiches that were to come out in 10-14 days with directions for wound care. There was no other information on the summary pertaining to the fall			F0689			

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F0689 SS = G	Continued from page 13 and/or R1's head injury. The facility investigation dated 8/28/25, included the aforementioned information pertaining to the fall. The form Skilled Nursing Facility-Fall investigation Form identified the time of the fall as 11:20 a.m. R1 was wearing slippers and also sustained a right shoulder abrasion in addition to the forehead laceration that was bleeding. R1's baseline behavior of the day was "anxious". This document also included a handwritten statement by scheduler (SCH)-A. The statement included SCH-A had wheeled R1 backwards onto the ramp, locked the breaks, was standing on the ramp with R1 holding onto the wheelchair and the remote, started to raise the ramp. The ramp stopped moving about six inches from the ground. SCH-A was looking for whatever stopped the ramp and stepped off the ramp, first checking right brake to make sure was on. When she stepped off the ramp, R1 began to roll forward and fell forward off her wheelchair, R1's head hit the ground first, writer ran to get help then attended to R1's bleeding head. Front wheels of the wheelchair were off the yellow foot stop by 3 inches, brakes off all the way on both sides. R1 landed about four feet from ramp. During an interview on 9/11/25 at 11:37 a.m. R1 stated she remembered being upset with PCP when SCH-A was assisting her onto the wheelchair lift. SCH-A was raising the lift when it suddenly stopped about 6 inches from the ground. When the lift stopped R1 remembered the wheelchair rolling forward on the lift and being propelled out of the chair onto the ground. R1 could not remember if SCH-A was standing on the lift with her or not. R1 reported increased pain and was bleeding from her head. During an interview on 9/10/25 at 1:40 p.m., SCH-A stated R1 had been in a clinic appointment with her primary care provider (PCP) and was angry with her provider. SCH-A explained as she was taking R1 out of the clinic to the van, R1 told SCH-A she was not going to her appointment with orthopedics the next day. SCH-A backed R1's wheelchair onto the lift platform so that she was facing away from the van. SCH-A walked to R1's left side (standing on the ground not on the lift as identified in the facility's written statement) and used the remote to raise the lift off the ground. SCH-A stated as she pushed R1 to the van and when she was loading R1 onto the lift, R1 was in a horrible mood and was talking loudly. When the lift was approximately 6 inches from the ground, the lift suddenly stopped. SCH-A explained while one hand was on R1's wheelchair handle and the other hand on the lift remote, she leaned back and looked away from R1 so she could check		F0689				

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F0689 SS = G	Continued from page 14 to see if the oxygen tank or wheelchair wheels were properly positioned such that they were not touching the back plate of the lift which needed to be clear of any objects. Before SCH-A could see why the lift had stopped R1 fell forward out of wheelchair landing on the ground with the front wheels of wheelchair hanging about three inches from the ground. SCH-A remembers R1 stating “Oh no here I go.” During a subsequent interview on 9/11/25 at 12:30 p.m., SCH-A indicated the lift did not come equipped with a seatbelt or torso restraint to use with wheelchairs and was unaware if R1 would required one; she did not have either on her wheelchair. SCH-A further stated R1 was not holding onto the yellow lift handrails, and she had not provided instruction for R1 to hang on. SCH-A stated although the clinic staff thought R1 threw herself off the lift because she was angry, she had known R1 for many years and did not believe R1 would intentionally throw herself out of her chair onto the ground. SCH-A stated she was trained on how to run the bus and wheelchair lift by maintenance man (MM)-A and had previous history of driving a facility bus/van and use of wheelchair lifts. SCH-A further stated had not received any re-education since the incident on 8/28/25. During an interview on 9/11/25 at 2:38 p.m., clinic manager (CM)-A stated when she arrived at the bus after the incident, the front wheels of the wheelchair were hanging off the front of the lift about 6 inches from the ground. R1 was on the ground in a fetal position in distress; she had a large laceration on her head and complaining of head pain. CM-A also stated there was no restraint on the wheelchair, just a mechanical lift sheet that had slid down in the chair. During an interview on 9/11/25 at 2:29 p.m., maintenance (MM)-A stated he was made aware of R1’s incident involving the lift on the bus on 8/28/25, by the administrator. Administrator had asked him to perform a post-incident inspection of the bus and wheelchair lift. MM-A stated MM-B and himself checked and re-checked the lift with a weight test, with each other in a wheelchair and moving around in the wheelchair; they could not find anything wrong with the lift. MM-A stated the facility did not have owner’s manual for the lift, he had found the manual online before the previous Administrator signed him off on 2/8/25. MM-A explained even though he had inspected the lift, he had not documented the post incident inspection so there was no written documentation the lift had been inspected after the incident. Review of SCH-A employee file revealed a Drivers Skills			F0689			

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F0689 SS = G	Continued from page 15 Validation checklist, with the instructions to check item the driver performs satisfactorily, mark with an “X” where further training is recommended. Leave any items not evaluated blank. Signed by MM-A on 7/2/25, identifying SCH-A as qualified driver, even though there were no check marks or “X” s located on the checklist. Review of MM-A employee file revealed a Drivers Skills Validation checklist, with the instructions to check item the driver performs satisfactorily, mark with an “X” where further training is recommended. Leave any items not evaluated blank. Signed by previous Administrator on 2/8/25, identifying MM-A as qualified driver, even though there were no check marks or “X” s located on the checklist. During and interview on 9/12/25 at 12:43 p.m., MM-A stated he did not read the directions on how to fill out the Drivers Skills Validation checklist, just remembers signing SCH-A's sheet and marking her as qualified. Review of manufacturer's owner's manual for Braun Century 2 wheelchair lift, dated 3/2010, for lift model number NCL917FIB-2 and serial number: EA-03856 included: Lift terminology: -the inner roll stop, and outer barrier sense weight to prohibit lift operation. The lift will not function if the inner rolls stop, or outer barrier are occupied. -The inner roll stop features a locking mechanism that prohibits the platform from lowering if the lock does not engage. The lift platform cannot be raised more than three inches above the ground level unless the outer barrier is in the vertical position. Lift Operation Safety: -read manual and supplements before operating lift. Read and become familiar with all safety precautions, pre-lift operation notes and details, operating instructions and manual operating instructions before operating the lift. -whenever a wheelchair passenger (or standee) is on the platform, the passenger must be positioned fully inside yellow boundaries, wheelchair brakes must be locked, inner roll stop and outer barrier must be up (vertical), outer barrier latches must be fully engaged, and passenger should grip both handrail (if able).		F0689				

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F0689 SS = G	Continued from page 16 -lift attendants must ensure that lift occupants keep hands, arms and all other body part within the lift occupant area and clear of moving parts -accidental activation of control switch(es) may cause unintended operation(s) -observe the passenger during lift operations. -do not use outer barrier as a brake -always keep owner's (operator's) manual in lift-mounted manual storage pouch -failure to follow these safety precautions may result in serious bodily injury and/or property damage. Review of facility policy entitled "Fleet Safety" dated 5/2025, included the following: Wheelchair securement- loading and unloading: -employees must be trained on how to use the proper equipment to board wheelchairs in passenger vans. This includes understanding how the lift works, operation of the lift and how to position wheelchair on the lift. -employees should make sure that lift gate is level with the ground before loading a wheelchair onto the lift. Employees should ensure that any stops are utilized to prevent rolling issues. Occupant Restraints: -the occupant must be secured in the wheelchair in case of an accident. A seat belt will prevent the occupant from being ejected from the chair, protecting them from additional injury.		F0689				
F0730 SS = E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility		F0730	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks does complete performance reviews of every nurse aide at least once every 12 months. The DON identified and completed overdue performance evaluations for all nurse aides whose annual reviews were past due. No staff were found to have performance issues impacting resident care. This has the potential to affect all residents by not		10/20/2025	

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F0730 SS = E	Continued from page 17 failed to ensure performance evaluations for 4 of 4 nursing assistants (NA-P, NA-D, NA-S, and NA-L) were provided within the past 12 months. Findings include: Review of nursing assistant (NA)-P employee record identified a hire date of 10/25/23 and did not include a performance evaluation since NA-P's hire date. During interview on 9/12/25, nursing assistant (NA)-P could not remember receiving a performance evaluation since she was hired. Review of (NA)-D's employee record identified a hire date of 11/10/22 and included a performance evaluation dated 3/13/23; there were no subsequent performance evaluations included in her record. Review of NA-S employee record identified a hire date of 4/15/22 and included a performance review dated 3/13/23; there were no subsequent performance evaluations included her the record. During interview on 9/12/25 at 8:27 a.m., NA-S could not remember receiving a performance evaluation since 2023. Review of NA-L's employee file identified a hire date of 2/18/20, a performance evaluation for 2022 was found but no other performance evaluation were located in her file. During an interview on 9/12/25 at 7:40 a.m., director of nursing (DON) indicated she had not done any performance evaluations for nursing assistants in her three years as DON at the facility. During an interview on 9/12/25 at 12:30 p.m., Administrator indicated there was no policy for annual evaluations of nursing assistants but was an expectation they were completed.		F0730	Continued from page 17 ensuring that nurse aides maintain competency and receive timely performance feedback. A full audit of all nursing department personnel files was conducted to verify that performance evaluations were completed and placed in employee files. The facility implemented a Performance Evaluation Tracking System maintained by HR to monitor due dates for all evaluations. The HR Manager or designee will conduct monthly audits of the evaluation tracking log to verify all staff reviews are current. Results of audits will be reviewed monthly at the QAPI meeting to monitor for sustained compliance.			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 20, 2025

Administrator
Glenoaks Senior Living Campus
100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

Re: State Nursing Home Licensing Orders
Event ID: 1D66B5-H1

Dear Administrator:

The above facility survey was completed on September 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

**Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728**

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/10/25 through 9/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			10/20/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H53603260 (260730) with a licensing orders issued at 20830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.		20000				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts		20830	Corrected, state orders do not require a POC.		10/20/2025	

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20830	Continued from page 2 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to follow manufacturer's safety guidelines for operating a wheelchair lift for 1 of 1 resident (R1). The facilities failures resulted in actual harm when R1 fell to the ground and sustained a head laceration that required transfer to the hospital emergency department for treatment. Findings include: Facility reported incident (FRI) #361588 submitted on 8/28/25, identified on 8/28/25, R1 experienced a fall from the facility transport bus while being transferred via the wheelchair lift. The incident occurred at approximately 11:30 a.m. during a scheduled clinic visit. R1 was being loaded onto the bus by trained staff (scheduler (SCH)-A). R1's significant change Minimum Data Set (MDS) dated 8/24/25, indicated R1 did not have cognitive impairment, had diagnoses of fractured hip, chronic obstructive pulmonary disease (COPD), R1 was dependent on staff for activities of daily living (ADLs), had a history of falls, and used oxygen. R1 had verbal behaviors and rejected cares. R1 was dependent on staff for self-care and indoor mobility, used manual wheelchair, and had impairment on one lower extremity. R1's mobility and transfer care plan dated 7/9/25, indicated R1 had a self-care deficit as evidenced by R1 requiring assistance with ADLs, impaired balance during transfers and/or walking. The following interventions were included: -R1 used a wheelchair and required staff to propel it -R1 requires assist of 1 with bed mobility -R1 required assist of two staff for toileting -R1 requires assist of two staff for transfers R1's mood and behavior care plans dated 7/9/25, did not identify target behaviors that R1 had displayed and/or had a history of. The care plan included focus for behavior which identified "alteration and at risk for		20830				

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20830	Continued from page 3 negative statements, repetitive questions, verbalizations, persistent anger with staff or others, self-depreciation, expressions of unrealistic fears, sadness, crying, repetitive movements, withdrawn/reduced socialization related to diagnoses of depression.” The care plan also had the focus of R1 had a potential for “psycho-social well-being deficit and is at risk for changes in appetite, sleep patterns, ADL’s, mood, socialization and increased sensitivity to environment,” An additional focus included R1 had the potential for “episodes of alteration in mood as evidenced by restlessness, easily fatigued, being irritable, having headaches/stomachaches, excessive worrying or difficulty controlling feelings of worry and having trouble falling asleep and/or staying asleep related to diagnosis of anxiety.” R1’s progress note dated 8/28/25 at 3:33 p.m., indicated R1 went to the emergency department after a fall while be loaded into the facility bus. R1 returned to Glen Oaks with no changes to medications. R1’s progress note dated 8/29/25 at 8:31 p.m., described the fall incident that occurred on 8/28/25 at 11:20 a.m. The note identified, R1 was taken to a doctor appointment by staff trained to operate the facility bus and passed driver assessment. They arrived at clinic at 10:25 a.m. and were taken to exam room. Medical doctor (MD)-A and R1 had a heated discussion over her antianxiety and opioid medications. MD-A ended the appointment with the mention of R1 returning to hospice to help manager her anxiety and pain. SCH-A took R1 to the bus and was loading R1 backwards onto the ramp, locked the brakes, was standing on the ramp and holding R1’s wheelchair while raising the ramp. Ramp stopped moving about six inches from the ground. SCH-A was looking for what stopped the ramp and stepped off ramp. SCH-A first checked right brake to make sure was on. SCH-A stepped off the ramp and R1 fell forward off her wheelchair hitting her head on the ground first. Staff went to get help, then attended to R1’s bleeding head. Front wheels of wheelchair were off the yellow foot stop by three inches, brakes on all the way both sides. R1 obtained a four-centimeter laceration to right forehead as well as a hematoma directly right of eye in temporal area. R1 reported throbbing pain to head and denied pain anywhere else. R1’s Medical and Transport/Emergency Documentation Form dated 8/28/25, that was handwritten included, “11:20 fell in parking lot out of w/c [wheelchair] to pavement.” Right forehead laceration. R1’s hospital emergency department after visit summary		20830				

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20830	Continued from page 4 (AVS) dated 8/28/25 identified R1 was evaluated for a fall with injury; laceration to forehead. The AVS identified R1 had stiches that were to come out in 10-14 days with directions for wound care. There was no other information on the summary pertaining to the fall and/or R1’s head injury. The facility investigation dated 8/28/25, included the aforementioned information pertaining to the fall. The form Skilled Nursing Facility-Fall investigation Form identified the time of the fall as 11:20 a.m. R1 was wearing slippers and also sustained a right shoulder abrasion in addition to the forehead laceration that was bleeding. R1’s baseline behavior of the day was “anxious”. This document also included a handwritten statement by scheduler (SCH)-A. The statement included SCH-A had wheeled R1 backwards onto the ramp, locked the breaks, was standing on the ramp with R1 holding onto the wheelchair and the remote, started to raise the ramp. The ramp stopped moving about six inches from the ground. SCH-A was looking for whatever stopped the ramp and stepped off the ramp, first checking right brake to make sure was on. When she stepped off the ramp, R1 began to roll forward and fell forward off her wheelchair, R1’s head hit the ground first, writer ran to get help then attended to R1’s bleeding head. Front wheels of the wheelchair were off the yellow foot stop by 3 inches, brakes off all the way on both sides. R1 landed about four feet from ramp. During an interview on 9/11/25 at 11:37 a.m. R1 stated she remembered being upset with PCP when SCH-A was assisting her onto the wheelchair lift. SCH-A was raising the lift when it suddenly stopped about 6 inches from the ground. When the lift stopped R1 remembered the wheelchair rolling forward on the lift and being propelled out of the chair onto the ground. R1 could not remember if SCH-A was standing on the lift with her or not. R1 reported increased pain and was bleeding from her head. During an interview on 9/10/25 at 1:40 p.m., SCH-A stated R1 had been in a clinic appointment with her primary care provider (PCP) and was angry with her provider. SCH-A explained as she was taking R1 out of the clinic to the van, R1 told SCH-A she was not going to her appointment with orthopedics the next day. SCH-A backed R1’s wheelchair onto the lift platform so that she was facing away from the van. SCH-A walked to R1’s left side (standing on the ground not on the lift as identified in the facility's written statement) and used the remote to raise the lift off the ground. SCH-A stated as she pushed R1 to the van and when she was loading R1 onto the lift, R1 was in a horrible mood and		20830				

Minnesota State Department of Health

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20830	Continued from page 5 was talking loudly. When the lift was approximately 6 inches from the ground, the lift suddenly stopped. SCH-A explained while one hand was on R1’s wheelchair handle and the other hand on the lift remote, she leaned back and looked away from R1 so she could check to see if the oxygen tank or wheelchair wheels were properly positioned such that they were not touching the back plate of the lift which needed to be clear of any objects. Before SCH-A could see why the lift had stopped R1 fell forward out of wheelchair landing on the ground with the front wheels of wheelchair hanging about three inches from the ground. SCH-A remembers R1 stating “Oh no here I go.” During a subsequent interview on 9/11/25 at 12:30 p.m., SCH-A indicated the lift did not come equipped with a seatbelt or torso restraint to use with wheelchairs and was unaware if R1 would required one; she did not have either on her wheelchair. SCH-A further stated R1 was not holding onto the yellow lift handrails, and she had not provided instruction for R1 to hang on. SCH-A stated although the clinic staff thought R1 threw herself off the lift because she was angry, she had known R1 for many years and did not believe R1 would intentionally throw herself out of her chair onto the ground. SCH-A stated she was trained on how to run the bus and wheelchair lift by maintenance man (MM)-A and had previous history of driving a facility bus/van and use of wheelchair lifts. SCH-A further stated had not received any re-education since the incident on 8/28/25. During an interview on 9/11/25 at 2:38 p.m., clinic manager (CM)-A stated when she arrived at the bus after the incident, the front wheels of the wheelchair were hanging off the front of the lift about 6 inches from the ground. R1 was on the ground in a fetal position in distress; she had a large laceration on her head and complaining of head pain. CM-A also stated there was no restraint on the wheelchair, just a mechanical lift sheet that had slid down in the chair. During an interview on 9/11/25 at 2:29 p.m., maintenance (MM)-A stated he was made aware of R1’s incident involving the lift on the bus on 8/28/25, by the administrator. Administrator had asked him to perform a post-incident inspection of the bus and wheelchair lift. MM-A stated MM-B and himself checked and re-checked the lift with a weight test, with each other in a wheelchair and moving around in the wheelchair; they could not find anything wrong with the lift. MM-A stated the facility did not have owner’s manual for the lift, he had found the manual online before the previous Administrator signed him off on 2/8/25. MM-A explained even though he had inspected the		20830				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2025	
NAME OF PROVIDER OR SUPPLIER Glenoaks Senior Living Campus				STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE , NEW LONDON, Minnesota, 56273			
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20830	Continued from page 6 lift, he had not documented the post incident inspection so there was no written documentation the lift had been inspected after the incident. Review of SCH-A employee file revealed a Drivers Skills Validation checklist, with the instructions to check item the driver performs satisfactorily, mark with an “X” where further training is recommended. Leave any items not evaluated blank. Signed by MM-A on 7/2/25, identifying SCH-A as qualified driver, even though there were no check marks or “X” s located on the checklist. Review of MM-A employee file revealed a Drivers Skills Validation checklist, with the instructions to check item the driver performs satisfactorily, mark with an “X” where further training is recommended. Leave any items not evaluated blank. Signed by previous Administrator on 2/8/25, identifying MM-A as qualified driver, even though there were no check marks or “X” s located on the checklist. During and interview on 9/12/25 at 12:43 p.m., MM-A stated he did not read the directions on how to fill out the Drivers Skills Validation checklist, just remembers signing SCH-A's sheet and marking her as qualified. Review of manufacturer's owner's manual for Braun Century 2 wheelchair lift, dated 3/2010, for lift model number NCL917FIB-2 and serial number: EA-03856 included: Lift terminology: -the inner roll stop, and outer barrier sense weight to prohibit lift operation. The lift will not function if the inner rolls stop, or outer barrier are occupied. -The inner roll stop features a locking mechanism that prohibits the platform from lowering if the lock does not engage. The lift platform cannot be raised more than three inches above the ground level unless the outer barrier is in the vertical position. Lift Operation Safety: -read manual and supplements before operating lift. Read and become familiar with all safety precautions, pre-lift operation notes and details, operating instructions and manual operating instructions before operating the lift. -whenever a wheelchair passenger (or standee) is on the platform, the passenger must be positioned fully inside yellow boundaries, wheelchair brakes must be locked,		20830				

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20830	Continued from page 7 inner roll stop and outer barrier must be up (vertical), outer barrier latches must be fully engaged, and passenger should grip both handrail (if able). -lift attendants must ensure that lift occupants keep hands, arms and all other body part within the lift occupant area and clear of moving parts -accidental activation of control switch(es) may cause unintended operation(s) -observe the passenger during lift operations. -do not use outer barrier as a brake -always keep owner's (operator's) manual in lift-mounted manual storage pouch -failure to follow these safety precautions may result in serious bodily injury and/or property damage. Review of facility policy entitled "Fleet Safety" dated 5/2025, included the following: Wheelchair securement- loading and unloading: -employees must be trained on how to use the proper equipment to board wheelchairs in passenger vans. This includes understanding how the lift works, operation of the lift and how to position wheelchair on the lift. -employees should make sure that lift gate is level with the ground before loading a wheelchair onto the lift. Employees should ensure that any stops are utilized to prevent rolling issues. Occupant Restraints: -the occupant must be secured in the wheelchair in case of an accident. A seat belt will prevent the occupant from being ejected from the chair, protecting them from additional injury. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible, and staff are deemed competent to operator's instructions. The director of nursing or designee should conduct audits of the delivery of care with lift use and		20830				

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20830	Continued from page 8 competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			20830			