DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

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

RE: CCN: 245360
Cycle Start Date: November 17, 2022

Dear Administrator:

On December 9, 2022, we notified you a remedy was imposed. On January 17, 2023 the Minnesota Department 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 December 22, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 17, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 9, 2022, 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 February 17, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 22, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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December 28, 2022

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

RE: CCN: 245360
Cycle Start Date: November 17, 2022

Dear Administrator:

On December 9, 2022, we informed you that we may impose enforcement remedies.

On December 12, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2023.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $11,292, 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 February 17, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Glenoaks Senior Living Campus will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2023. 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)

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 17, 2023 (six months after the identification of noncompliance) 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:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 12/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/9/22, through 12/12/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H53606503C (MN00089090); however, no deficiencies were cited due to actions taken by the facility prior to the survey. As a result of the investigation, related deficiencies were cited at F600 and F609 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.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		12/22/22

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

Electronically Signed | 01/06/2023

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

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 4 of 4 residents (R2, R3, R5, and R7) who were verbally and/or physically abused by R1. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/21/22, identified R1 was moderately cognitively impaired. In addition, the MDS identified R1 displayed one to three days of behavioral symptoms, was independent with wheelchair mobility, and was diagnosed with history of a stroke and associated right sided weakness, along with borderline intellectual functioning. R1's Face Sheet identified R1 was diagnosed with paranoid personality disorder. R1's care plan printed 12/9/22, identified R1 displayed episodes of negative vocalizations, name calling, attention seeking behavior, yelling at staff and using foul language, along with his having a potential to be physically aggressive towards others. In addition, he was impulsive, impatient, wanted things done at the exact moment he requested, accused staff of doing or saying things, mocked other residents, yelled at them to shut up, and acted out when redirected. R1's interventions directed staff to intervene as	F 600	F:600 To ensure the safety of the other residents at the time of the incident, Resident, (R1), was separated from the other residents and the piano player that were affected by R1□s behaviors. R1□s motorized scooter, that was being used in a manner that posed a safety risk to other residents, was replaced with a standard wheelchair to allow R(1) continued mobility, while ensuring immediate safety of other residents. R(1)□s care plan was reviewed and updated to include these changes and was discussed with the resident. R(1) is on a progressive training schedule to demonstrate ability to safely operate the motorized scooter safety and without any behavioral problems that could pose a risk or discomfort to other residents. This is being monitored through the medication administration record. This training for R(1) is being done under the direct supervision of staff. When R(1) can demonstrate he can safely operate his scooter, privileges will slowly be expanded for increased use. R(1) can continue to operate his scooter when on shopping trips off the facility property. In the event R91) is unable to safely operate his electric scooter in the future, he will	

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F 600	Continued From page 2 necessary to protect the rights and safety of other residents. R1's care plan lacked documented evidence related to unsafe electric wheelchair use or related interventions. R2's quarterly MDS dated 10/18/22, identified R2 was severely cognitively impaired. R2's medical record lacked documented evidence R2 was involved in an incident with R1. R3's significant change MDS dated 11/4/22, identified R3 was moderately cognitively impaired. R3's medical record lacked documented evidence R3 was involved in an incident with R1. R5's admission MDS dated 11/30/22, identified R5 was cognitively intact. R5's medical record lacked documented evidence R5 was involved in an incident with R1. R7's quarterly MDS dated 10/21/11, identified R7 was moderately cognitively impaired. R7's medical record lacked documented evidence R7 was involved in incidents with R1. R1's progress notes identified the following behavioral events: -7/19/22: R1 mocked residents [unidentified] "a lot" who screamed out in pain that morning. -8/23/22: R1 mimicked another resident [unidentified] and yelled out in the lobby area. -9/9/22: R1 mocked another resident [unidentified] with hand movements. -9/9/22: R1 yelled, "She does not know anything and all she does is blabber her mouth about nothing!" after the nurse, who conversed with another resident [unidentified], explained to R1 she was busy at that moment.	F 600	continue to use the manual wheelchair to ambulate. Staff were re-educated on the Abuse and Neglect Policy to include requirements of timely reporting of incidents to upper management, so that a proper report can be submitted and followed up with a timely investigation. Timely reporting is required within 2 hours. Staff signature sheets were used to verify that the staff read and understood this information. This was completed on the dates of December 21 and 22, 2022. Additionally, staff will have a second round of education on the dates of January 17 and 18, 2023. The incident involving R(1) and the other affected residents was shared at QAPI meeting held on 12-21-2022. The Abuse and Neglect Policy and the reporting procedures will be reviewed again in the monthly QAPI meetings from January through May, 2023, and on-going as needed, to ensure continued compliance and that the incident does not recur.	

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F 600	Continued From page 3 -9/20/22: R1 was in the hallway and screamed as he tried to mimic a resident [unidentified] across the hall from him. -9/28/22: R1 was in front of R3's room and mimicked her. R3 "was upset." -10/9/22: R1 screamed "shut up" and "stop being noisy" to other residents [unidentified]. In addition, he made fun of and mocked two other residents [unidentified] and called them "names" [not identified]. -10/10/22: R1 "rammed" his [electric] wheelchair into two residents [unidentified] when he entered the dining room and told the residents to "get out of [his] way." -10/20/22: R1 maneuvered his [electric] wheelchair "full speed" from the front desk toward another resident [unidentified] and proceeded to "hit" the back of the resident's wheelchair, and then the wall, after he failed to wait for her to get out of his path. When staff reminded him to watch for other residents he yelled, "No, she should get the hell out of my way and wake up!" -11/28/22: R1 was in the dining room and mocked residents [unidentified] and took food off of other residents' [unidentified] plates. -12/3/22: R1 called [R5] a derogatory name and told [R5] to get out of the dining room so he could eat in peace. R1's progress note dated 12/4/22, at 1:30 p.m., identified while R1 ate his breakfast in the lobby area he stated to the staff he could eat where he wanted, just not where the "F*** piano player [R5]" was. When R1 started to push chairs around that were near him after he was asked to eat in his room, residents [unidentified] asked to be taken to their rooms as they did not want to be near R1. During the lunch meal, R1 beeped his wheelchair horn and stared at other residents.	F 600		

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F 600	Continued From page 4 Staff asked him to remove himself from the dining room. On the way out of the dining room, R1 wheeled his electric wheelchair into the back of R2's wheelchair to push him out of the way. R1 pushed R2's wheelchair approximately two feet. In response, R1 yelled "Ow," which was heard by staff in the memory care unit. No injury to R1 was observed at that time. R1 was instructed not to return to the dining room, which he refused, and started to yell at staff. The residents [unidentified] who were in the dining room "were afraid of [R1] and did not want [R1] in dining room as they did not feel comfortable with [R1] there." Staff called 911 and administration as staff and residents [unidentified] did not feel safe around [R1]. After the police arrived, R1 was transferred to bed to keep him and residents safe. The progress note lacked documented evidence of any adjusted/new interventions to mitigate R1's risk of abusing other residents. A Vulnerable Adult (VA) Maltreatment Report submitted to the State Agency (SA) on 12/5/22, at 10:10 a.m. identified approximately 21 hours earlier, on 12/4/22, R1 became upset when R5 played the piano in the dining room and "ran" his electric wheelchair into R2. R1 was asked to return to his room. In response, R1 yelled at staff and other residents [unidentified] and used his wheelchair to "intimidate staff and residents." In addition, the report identified the police were contacted in order to help de-escalate the situation as R1 "was using his [wheelchair] as [a] weapon" and would not exit the dining room or return to his room when instructed to do so. The report identified R1's electric wheelchair was not allowed to be used after the incident and R1 was provided with a manual wheelchair. However, the report lacked evidence of interventions	F 600		

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F 600	Continued From page 5 implemented for R1 when he was in the manual wheelchair to decrease the risk of him being verbally or physically aggressive towards other residents. R1's medical record from 7/19/22, through 12/9/22 lacked documented evidence R1's behavioral events were investigated, his behaviors were comprehensively assessed and/or analyzed, his target behaviors were monitored, his medical provider was updated on his behaviors, a psychological/psychiatric consult was initiated, or that his care planned behavioral interventions were evaluated and/or adjusted to decrease the risk of resident directed behaviors. When interviewed on 12/9/22, at 10:56 a.m. R1 stated staff took away his electric wheelchair based on conversations the staff had with other staff after "they got some votes to tell others bad things about me." He felt these staff lied and he denied he had ever hit anyone while he used the electric wheelchair or used the wheelchair in any inappropriate way. He stated, "I do not have any reason to lie." R1 confirmed the wheelchair had never been taken away before. R1 explained his mood as "happy" and he denied he ever gets angry. He stated, "It does no good to get mad." In addition, he denied he ever talked bad to or mocked/mimicked other residents. He felt he had good relationships with others. When interviewed on 12/9/22, at 12:48 p.m. R5 stated R1 was upset when he played the piano in which R1 told him not to play the piano, and when R5 told R1 he would continue to play, R1 "would swing by the piano and glare at me." R5 explained R1 threw the piano bench around and pounded on the keys while he yelled and swore:	F 600		

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F 600	Continued From page 6 "He had a bully attitude and it felt like [R1] wanted to push people around." R5 explained the facility took R1's wheelchair from him as the facility had "to protect other clients as [R1] was a problem." R5 explained he felt sorry for R1 and was not afraid of him; however, he attempted to ignore him. During an interview on 12/9/22, at 1:18 p.m. dietary staff (DS)-A stated R1 made fun of, yelled at, and told other residents to shut up: to the point the residents did not want R1 in the dining room when they were present. In addition, DS-A identified R1 made fun of R7 and often mimicked her. When interviewed on 12/9/22, at 1:37 p.m. nursing assistant (NA)-A stated she witnessed R1 verbally and physically mock and/or mimic other residents in which R1 mimicked others every day as he "like[d] to make fun of staff or residents." In addition, R1 once banged on the bathroom door and attempted to enter while she showered another resident which "scared the living crap out of [the resident]," and R1 attempted to run over other residents' feet while R1 was in his electric wheelchair. NA-A was unable to recollect the exact resident names. In addition, she confirmed she witnessed R1 run into the piano bench intentionally when R5 sat upon it as R1 was upset with R5 as he played the piano. She explained R5 "freaked out a little bit" and was startled. She confirmed there were times when other residents asked to not eat in the dining room if R1 was present and/or told her they were scared of R1. Again, she was unable to recollect exact resident names. NA-A stated, "[R1] is [R1]." She explained R1 spent the majority of his day in the electric wheelchair, prior to 12/5/22, and R1 would often	F 600		

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F 600	Continued From page 7 go back and forth down the hallways. She identified she overall just tried to keep other residents away from R1 and to tell R1 his behaviors were not nice and he should not do them. During interview on 12/9/22, at 2:43 p.m. licensed practical nurse (LPN)-A stated she had witnessed R1 yell at, mimic, and/or be rude to other residents as R1 liked to mimic residents who screamed or made noises. She identified R1 targeted R7 where he screamed at and mimicked her "a lot." She explained when she asked him why he did or said the things he did, R1 told her, "They are so I can." In addition, she witnessed R1 purposefully run into, or ran over toes, of other residents with his electric wheelchair. She was unable to recollect the exact residents R1 ran into, or who's toes he ran over. LPN-A stated staff anticipated other residents who may be in his path when he propelled his electric wheelchair down the hallway as this often upset him and he would purposefully run into them. LPN-A explained she updated management when she witnessed R1's past wheelchair aggression; however, she acknowledged she did not update management every time R1 was verbally abusive towards other residents. Overall, she stated she just documented the episodes in order for management to track R1's behaviors. During interview on 12/9/22, at 3:02 p.m. registered nurse (RN)-A stated she had witnessed R1 yell, scream, and swear at other residents. In addition, she witnessed R1 maneuver his electric wheelchair in a threatening manner towards other residents and had also witnessed him intentionally run into R2 when R2's wheelchair was positioned within the dining room	F 600		

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F 600	Continued From page 8 doorway on 12/4/22. After that, R1 refused to return to his room and while he was by nurses station/lobby area he raised his arms and screamed in front of other residents. RN-A stated R1 was very demanding and became mad if he were asked to wait. RN-A stated if abuse was witnessed her first priority was to make resident(s) safe and then she would update management. In addition, she would update all staff, who worked at that time, of the intervention(s) to keep resident(s) safe and she was expected to complete a skin assessment if the abuse was physical. The skin assessment would be documented in the resident's medical record. RN-A stated she was unsure how to manage R1's behaviors and she acknowledged interventions for R1 were "hard" as one moment he was fine and the next he became mad. Overall, staff kept others out of his way, attempted to keep R1 in his room, and explained to R1 he could not do the exhibited behavior. She explained R1 appeared to exhibit increased behaviors in the past six months and "nothing [had] been done until this recent episode" when R1's wheelchair was removed from his use, other than for appointments. RN-A was unsure of any other interventions implemented to decrease R1's risk of verbal/emotional abuse towards other residents. When interviewed on 12/9/22, at 3:36 p.m. social services designee (SD)-A stated she had witnessed R1 mock other residents and demonstrated defiant backlash if he did not get his way: "He [would] retaliate and do something." She explained, "The dining room seem[ed] to be an issue, especially if he [did] not like something." In addition, she identified music or noises, especially louder noises, appeared to trigger R1.	F 600		

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F 600	Continued From page 9 She explained R1's mentality level was that of a young child and his behaviors "came out because of that:" "He will either chose to listen or not." SD-A explained R1 was talked to in the past related to his unsafe wheelchair use and the episodes where he ran into others; however, she acknowledged R1 was not allowed to use his electric wheelchair only after the recent event with R2. She stated interventions were hard to find for R1; however, she was unsure if nursing completed behavioral assessment(s) for R1 to develop or adjust his plan of care. She denied she participated in any comprehensive behavioral assessment and/or analysis process for R1, or completed a mood/depression assessment with him, despite her acknowledgement R1's behavior intensity had increased over the past couple months. In addition, she denied she interviewed and/or assessed other resident(s) after resident-to-resident events with R1. SD-A identified R1 now utilized a standard wheelchair to protect other residents from physical abuse; however, she was unsure of any new or adjusted interventions to decrease R1's risk of verbal/emotional abuse towards other residents. During interview on 12/9/22, at 4:15 p.m. assistant director of nursing (ADON)-A stated staff were expected to report abuse to management right away as the facility does not tolerate "bullying." After ADON-A was updated on R1's behaviors from 7/19/22 through 12/4/22, she acknowledged the behaviors should have been reported to management and investigated. She identified R1 was triggered by noises and when he did not get immediate attention or nursing care right when he wanted it. ADON-A stated she was unaware if any comprehensive behavioral assessments were completed on R1. She denied	F 600		

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F 600	Continued From page 10 she was made aware of the extent of R1's behaviors prior to his episode with R2. She identified staff should communicate more and be aware of R1's mood and if he was in his wheelchair he should be monitored at all times: however, she was unsure of R1's interventions to help mitigate his resident directed behaviors. When interviewed on 12/12/22, at 11:11 a.m. LPN-B stated if resident-to-resident abuse were witnessed, she expected the resident(s) to be separated, assessed and monitored for any potential concerns related to the abuse, a plan formulated to protect the residents, a completed assessment to determine what caused the behavior, and interventions formulated to help mitigate it from happening again. If a resident were to be unsafe with an electric wheelchair, she expected a wheelchair screening to be performed and the event to be assessed, in which the wheelchair may be required to be removed from resident use. LPN-B confirmed she had witnessed R1 unsafely use his wheelchair a couple months ago when he propelled it too fast down a hallway. She gave him a warning to slow down; however she proceeded with no other actions. LPN-B denied she was aware staff were to be concerned about other resident(s) feet when R1 propelled his electric wheelchair. She indicated if such events occurred, she expected staff to monitor the resident(s) toes for a couple of days following the incident to observe for injury and/or changes in the resident's mobility. She does not recall any such monitoring for any residents. LPN-B stated she was not too familiar with R1's behaviors towards other residents as R1's behaviors were mainly in the evenings; however, she explained R1 was not a fan of someone playing music or of change and he	F 600		

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F 600	Continued From page 11 belittled others who were mentally disabled, or who yelled out, whom he targeted and who would trigger his behaviors. She indicated the facility does not complete behavior assessments and further indicated R1's wheelchair use should have been evaluated back in October. She identified R1 was able to propel his electric wheelchair in any resident allowed area of the building prior to the incident with R2. LPN-B identified interventions used to protect other residents from R1's behaviors centered about R1 being monitored and providing R1 options of where he wished to eat his meals, along with educating R1 on his inappropriate behaviors. When interviewed on 12/12/22, at 1:21 p.m. the director of nursing (DON) stated she expected staff to report any resident-to-resident abuse to her so she could determine if the altercation required reporting to the SA. She explained staff updated her R1 was "screaming and hollering" as he did not want "another gentleman" to play the piano on 12/3/22 as R1 did not like piano playing noise and that R1 unsafely utilized his wheelchair on 12/4/22. After the DON was updated on R1's resident directed behaviors from 7/19/22 through 12/4/22, she acknowledged, during the approximate eight weeks in her position, she was not made aware of the extent of R1's behaviors; however, she was aware R1 was not patient, he wanted things right at the time of his wanting, and he mocked others. In addition, she was aware of R1's past history of unsafe wheelchair use. She explained she thought the electric wheelchair was removed from his use "months ago" and stated she had witnessed him using the wheelchair after that; however, she never questioned the continued use and assumed the timeframe for its removal had ended. The DON stated R1's	F 600		

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F 600	Continued From page 12 demonstrated behaviors that occurred since she started her position should have been reported to her for investigation and follow-up in order to protect all residents. The DON denied she had interviewed other residents, or directed other staff, to investigate resident responses to interactions with R1 and she denied she conversed with therapy about an assessment for R1 and his electric wheelchair use despite R1 being a "repeat offender." The DON denied knowledge of R1's behaviors being comprehensively assessed. She explained such an assessment could make his life better as interventions and/or referrals would be evaluated and implemented. During interview on 12/12/22, at 4:59 p.m. R1's medical doctor (MD) stated she was unaware of R1's unsafe electric wheelchair use or his behaviors directed at other residents. She explained she expected to be updated on such information so that discussions with facility staff could be completed to help mitigate R1's behaviors and to protect all residents within the facility. An Unmanageable Residents policy revised 4/10, identified each resident was to be provided a safe place to reside. The policy directed that if a resident's behavior was abusive, hostile, assaultive, or unmanageable in any way that jeopardized his or her safety or the safety of others, staff must immediately perform the following: provide for safety of all concerned, notify the resident's medical provider, notify the DON, and notify the resident's representative. In addition, the policy directed staff to document the incident in the medical record and complete an incident report.	F 600		

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F 600	Continued From page 13 A Behavioral Assessment, Intervention, and Monitoring policy revised 3/19, identified behavioral symptoms were to be identified using facility-approved behavioral screening tools and the comprehensive assessment. The policy directed, as part of the comprehensive assessment, staff to evaluate the residents usual mood and behavior patterns, methods of communicating needs, typical and past responses to mood fluctuations, and previous patterns of coping mechanisms. In addition, the policy directed the following: staff were to update the medical provider with changes in resident behaviors, any new or changed behavioral symptoms were to be thoroughly evaluated in order to identify causes and address any modifiable factors related to the behavior, the care plan was to incorporate the findings of the comprehensive assessment, and the behaviors were to be monitored and interventions adjusted accordingly. A Nursing Facility Abuse, Prevention, Identification, Investigation and Reporting Policy updated 3/3/22, identified abuse included verbal, physical, and mental abuse. The policy identified examples of verbal abuse consisted of oral, written, sounds and/or gestures that harassed, mocked, insulted or ridiculed another, and/or when a person was yelled at, or hovered over and intimidated. Examples of physical abuse were identified as acts of physical aggression where the person was hit, kicked, grabbed, pushed, shoved, or were threatened with gestures. Mental abuse was defined as the use of verbal or nonverbal conduct which caused, or had the potential to cause, a resident to experience humiliation, intimidation, fear, shame, agitation, or	F 600		

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F 600	Continued From page 14 degradation. The policy directed staff to update the abuse immediately to the administrator in which the administrator, or designee, was directed to review documentation in the resident's record, to assess the resident for injury, to update the primary care provider and responsible party, and attempt to obtain witness statement from all know witnesses. In addition the policy directed staff to immediately implement measures to prevent further abuse while the investigation continued.	F 600		
F 609 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	F 609		12/22/22

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F 609	Continued From page 15 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 allegations of resident-to-resident abuse to the State Agency (SA) immediately, within 2 hours, of an allegation of abuse for 4 of 4 residents (R2, R3, R5, and R7) who were abused by R1. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/21/22, identified R1 was moderately cognitively impaired. In addition, the MDS identified R1 displayed one to three days of behavioral symptoms and was diagnosed with history of a stroke and associated right sided weakness, along with borderline intellectual functioning. R1's face sheet identified R1 was diagnosed with paranoid personality disorder. R2's quarterly MDS dated 10/18/22, identified R2 was severely cognitively impaired and was diagnosed with Alzheimer's disease and dementia. R3's significant change MDS dated 11/4/22, identified R3 was moderately cognitively impaired and was diagnosed with dementia and a psychotic (disconnection from reality) disorder. R5's admission MDS dated 11/30/22, identified R3 was cognitively intact and was diagnosed with an anxiety disorder. R1's face sheet identified R3 was diagnosed with adjustment disorder with	F 609	F 609: Staff were re-educated on the Abuse and Neglect Policy to include requirements of timely reporting of incidents to upper management, including that timely reporting for Vulnerable Adult Maltreatment Reports is required within 2 hours and followed up with a timely investigation. Education also included that timely reporting for Vulnerable Adult Maltreatment Reports is required within 2 hours. Staff signature sheets were used to verify that the staff read and understood this information. Education included the requirements to be informing upper management as well as family members of any affected residents when a Vulnerable Adult event occurs and a report is submitted. This instruction of staff was completed from 12/21/2022 through 12/22/2022. An additional round of staff training on Abuse and Reporting will be done again on December 17 and 18, 2023. To ensure the immediate safety of the other residents, Resident, (R1), was separated from the other residents and the piano player that were affected by R1□s behaviors. R1□s motorized scooter, that was being used in a manner that posed a safety risk other residents, was replaced with a standard wheelchair to allow R(1) continued mobility, while	

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F 609	Continued From page 16 depressed mood. R7's quarterly MDS dated 10/21/11, identified R7 was moderately cognitively impaired and displayed one to three days of behavioral symptoms. In addition, R7 was diagnosed with mild intellectual disabilities and manic depression (bipolar disease). Facility records lacked documented evidence the following incidents based on R1's, 7/19/22 - 12/3/22 progress notes, were reported to the SA: -7/19/22: R1 mocked residents [not identified] "a lot" who screamed out in pain that morning. -8/23/22: R1 mimicked another resident [not identified] and yelled out in the lobby area. -9/9/22: R1 mocked another resident [not identified] with hand movements. -9/9/22: R1 yelled, "She does not know anything and all she does is blabber her mouth about nothing!" after the nurse, who conversed with another resident [unidentified], explained to R1 she was busy at that moment. -9/20/22: R1 was in the hallway and screamed as he tried to mimic a resident [unidentified] across the hall from him. -9/28/22: R1 was in front of R3's room and mimicked her. R3 "was upset." -10/9/22: R1 screamed "shut up" and "stop being noisy" to other residents [unidentified]. In addition, he made fun of and mocked two other residents [unidentified] and called them "names" [not identified]. -10/10/22: R1 "rammed" his [electric] wheelchair into two residents [unidentified] when he entered the dining room and told the residents to "get out of [his] way." -10/20/22: R1 maneuvered his [electric] wheelchair "full speed" from the front desk toward	F 609	ensuring immediate safety of other residents. To prevent the deficient practice from recurring, any future events that require filing as a Vulnerable Adult report will be reviewed for timely reporting within the 2-hour time frame, by comparing the time of first report received to the time that the Vulnerable Adult Report was submitted. Reviews of timely reporting will be performed at QAPI meetings from January, 2023 through May, 2023 and as needed to ensure continued compliance. R(1)□s care plan was reviewed and updated to include these changes and was discussed with the resident. Additionally, the incident involving R(1) toward the other affected residents was shared at QAPI meeting held on 12-21-2022. Reviews of timely reporting will be performed at future QAPI meetings held from January, 2023 through May, 2023 and on-going as needed, to ensure continued compliance and that the deficient practice does not recur.	

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F 609	Continued From page 17 another resident [unidentified] and proceeded to "hit" the back of the resident's wheelchair, and then the wall, after he failed to wait for her to get out of his path. When staff reminded him to watch for other residents he yelled, "No, she should get the hell out of my way and wake up!" -11/28/22: R1 was in the dining room and mocked residents [unidentified] and took food off of other residents' [unidentified] plates. -12/3/22: R1 called [R5] a derogatory name and told [R5] to get out of the dining room so he could eat in peace. R1's progress note dated 12/4/22, at 1:30 p.m., identified while R1 ate his breakfast in the lobby area he stated to the staff he could eat where he wanted, just not where the "F*** piano player [R5]" was. When R1 started to push chairs around that were near him after he was asked to eat in his room, residents [unidentified] asked to be taken to their rooms as they did not want to be near R1. During the lunch meal, R1 beeped his wheelchair horn and stared at other residents. Staff asked him to remove himself from the dining room. On the way out of the dining room, R1 wheeled his electric wheelchair into the back of R2's wheelchair to push him out of the way. R1 pushed R2's wheelchair approximately two feet. In response, R1 yelled "OW," which was heard by staff in the memory care unit. R1 was instructed not to return to the dining room, which he refused, and started to yell at staff. The residents [unidentified] who were in the dining room "were afraid of [R1] and did not want [R1] in dining room as they did not feel comfortable with [R1] there." Staff called 911 and administration as staff and residents [unidentified] did not feel safe around [R1].	F 609		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 18 A Vulnerable Adult (VA) Maltreatment Report submitted to the SA on 12/5/22, at 10:10 a.m., identified approximately 21 hours earlier, on 12/4/22, R1 became upset when R5 played the piano in the dining room and "ran" his electric wheelchair into R2. This action pushed R2 approximately two feet and caused R1 to yell out "ow." R1 was asked to return to his room. In response, R1 yelled at staff and other residents [unidentified] and used his wheelchair to "intimidate staff and residents." In addition, the report identified the police were contacted in order to help de-escalate the situation as R1 "was using his [wheelchair] as [a] weapon" and would not exit the dining room or return to his room when instructed to do so. When interviewed on 12/9/22, at 1:37 p.m. nursing assistant (NA)-A stated she was expected to report such witnessed behavior to the nurse "right away" and she confirmed she witnessed R1 abuse other residents. NA-A stated she had not reported every witnessed incident of R1's abusive behavior toward other residents as "[R1] is [R1]" and she overall just tried to keep other residents away from R1. During interview on 12/9/22, at 2:43 p.m. licensed practical nurse (LPN)-A stated she was expected to contact management right away if abuse was witnessed and she confirmed she witnessed R1 abuse other residents. LPN-A explained she had updated management when she witnessed R1's past wheelchair aggression; however, she acknowledged she did not update management every time R1 was verbally abusive towards other residents. Overall, she stated she just documented the episodes in order for management to track R1's behaviors.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 19 During interview on 12/9/22, at 3:02 p.m. registered nurse (RN)-A stated the facility was required to report abuse to the SA within two hours of the allegation and/or witnessed abuse. She stated she had witnessed R1 abuse other residents and she contacted management to update them on R1's behaviors on 12/4/22; however, she stated she was instructed to wait on reporting the incident to the SA as more information needed to be collected. When interviewed on 12/9/22, at 3:36 p.m. social services designee (SD)-A stated she expected staff to report any behavior(s) that constituted abuse immediately to management as a VA report was expected to be filed within two hours to the SA. She explained timely VA reporting was important to ensure resident safety and protection. SD-A stated she had witnessed R1 abuse other residents; however, she did not report all of these episodes, which she acknowledged were reportable abuse. During interview on 12/9/22, at 4:15 p.m. assistant director of nursing (ADON)-A stated she expected staff to report abuse to management right away as the facility was expected to report abuse to the SA within two hours of the abuse. ADON-A stated R1's 12/4/22, incident with R2 was not reported as expected on 12/4/22, due to missed communication amongst the leadership team on who was expected to file the VA and thoughts she needed to gather more information about the incident. ADON-A denied she was educated on abuse reporting time frames between 12/4/22, and 12/9/22. After ADON-A was updated on R1's resident directed behaviors from 7/19/22, through 12/4/22, she acknowledged the	F 609		

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F 609	Continued From page 20 behaviors should have been reported to management and investigated, and those which met the definitions of abuse should have been reported to the SA within two hours. When interviewed on 12/12/22, at 1:21 p.m. the director of nursing (DON) stated she expected staff to report abuse to her so she could determine if the altercation required reporting to the SA within two hours of the event. She explained staff updated her on 12/3/22, that R1 was "screaming and hollering" as he did not want "another gentleman" to play the piano; however, she acknowledged she did not file the incident as she did not think the altercation was directed towards R5 and was unaware R1 called R5 inappropriate names. The DON stated she followed up with staff on 12/4/22, related to R1's behaviors that day; however, she explained she was not made aware R1 ran into R2, only that R1 attempted to "run over staff." After the DON was updated on R1's resident directed behaviors from 7/19/22, through 12/4/22, she acknowledged, during the approximate eight weeks in her position, she was not made aware of the extent of R1's behaviors; however, the behaviors demonstrated while in her position should have been reported to her for investigation and follow-up in order to protect all residents and to file a timely VA report if applicable. The DON denied staff were educated on abuse reporting time frames between 12/4/22, and 12/9/22. A Nursing Facility Abuse, Prevention, Identification, Investigation and Reporting Policy updated 3/3/22, identified abuse included verbal, physical, and mental abuse. The policy identified examples of verbal abuse consisted of oral, written, sounds and/or gestures that harassed,	F 609		

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F 609	Continued From page 21 mocked, insulted or ridiculed another, and/or when a person was yelled at, or hovered over and intimidated. Examples of physical abuse were identified as acts of physical aggression where the person was hit, kicked, grabbed, pushed, shoved, or were threatened with gestures. Mental abuse was defined as the use of verbal or nonverbal conduct which caused, or had the potential to cause, a resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. The policy directed all allegations of resident abuse were to be reported to the administrator immediately and then to the appropriate state entity (SA) no later than two hours after the allegation was made.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 28, 2022

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

Re: Event ID: XHKE11

Dear Administrator:

The above facility survey was completed on December 12, 2022 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	12/12/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/9/22, through 12/12/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED, H53606503C (MN00089090);	2 000		

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2 000	Continued From page 1 however, no licensing orders were issued due to actions taken by the facility prior to the survey. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		