Electronically delivered
November 30, 2021

Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

RE: CCN: 245402
Cycle Start Date: November 18, 2021

Dear Administrator:

On November 18, 2021, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 18, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 18, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(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 11/17/21, to 11/18/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5402024C (MN00077490) H5402026C (MN00075457) with a deficiency cited at F609. The following complaint was found to be SUBSTANTIATED: H5402025C (MN00075925) with a deficiency cited at F609. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		1/7/22

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

Electronically Signed | 12/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(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 1 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 immediately report to the State Agency (SA) and immediately report to the administrator an allegation of physical and mental/emotional abuse no later than 2 hours, for 1 of 3 residents (R2) who was reviewed for abuse. Findings include: Physical abuse: R2's quarterly Minimum Data Set (MDS) dated 9/29/21, indicated R2 was severely cognitively impaired and had diagnoses which included: Alzheimer's, depression and muscle weakness. The MDS identified R2 required extensive assistance of one staff with all ADL's. R2's care plan revised on 9/29/21, indicated R2 was vulnerable related to nursing home	F 609	F609 It is the policy of Glenwood Village Care Center to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of residents 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 harm. The alleged violation is to be reported to the administrator 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 establishment procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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 2 placement, physical limitations, and sensory impairments. The care plan instructed staff to refer to vulnerability assessment. Review of R2's Vulnerability /Risk Assessment dated 1/26/21, identified R2 was significantly at risk for potentially being abused by another person. Review of R2's progress note dated 8/17/21, indicated LPN-A was in the dining room completing the medication administration task when she heard a resident loudly say "ouch". LPN-A noted R3 quickly wheeled away from the dining room table where the sound came from. LPN-A questioned R3 about the incident and R3 stated," I pinched her (R2) because she was talking about me and I am sick of it". LPN-A approached R2, assessed her for injuries and asked R2 about the situation. Review of the Nursing Home Incident Report #343570 submitted to the SA identified physical abuse (pinching) occurred when R2 was seated in her wheelchair at the dining room table waiting for breakfast and R3 approached R2 in her wheelchair and R2 said "ouch". LPN-A approached the dining room table to investigate what had happened when R3 was observed to wheel away in her wheelchair. R2 informed LPN-A R3 had pinched her. LPN-A asked R3 about the incident and R3 indicated she was tired of R2 talking about her and she confirmed she had pinched her. The report identified the incident occurred on 8/17/21, at 7:40 a.m. and was reported to the SA on 8/17/21, at 4:03 p.m. over eight hours and 23 minutes after the incident had been reported by staff.	F 609	Resident R2; Care plan has been reviewed and the annual Vulnerability assessment has been completed on 12/1/2021. All residents in the facility have a Vulnerability assessment completed on admission, annually and as needed, and their plan of care reflects the vulnerability focus. Glenwood Village Care Center reviewed and revised the following facility policies: Abuse Prevention, Elder Justice and Vulnerable Adult Protection. Glenwood Village Care Center nursing staff have been re-educated on when to report all alleged violations, definition of Abuse, and serious bodily harm. Dates of education; 11/29/21 and 12/2/2021. All other staff will be re-educated on December 17, 2021. An audit will be performed by administrator of designee after every self-reported complaint for compliance. The Facility Administrator or designee is responsible for overall compliance. Results of audits to be communicated to facility QA committee. The facility alleges that it will be in substantial compliance by: January 7, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(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 3	F 609		

On 11/17/21, at 1:08 p.m. LPN-A confirmed R2 was seated in her wheelchair in the dining room when LPN-A overheard R2 say "ouch". LPN-A looked up and observed R3 wheeling herself quickly out of the dining room area. LPN-A indicated when she questioned R3 about the incident, R3 said she pinched R2 because "she was talking about me and I'm sick of it". LPN-A indicated when she asked R2 about the incident, R2 verified R3 had pinched her and stated, "I wish I could pinch her back". LPN-A stated she reported the incident immediately to the charge nurse (CN)-A. LPN-A indicated she was not able to recall the day it happened however remembered the incident occurred around 7:00 a.m.

On 11/18/21, at 9:36 a.m. CN-A confirmed LPN-A reported the allegation of physical abuse involving R3 pinching R2 to her. CN-A verified she had reported the incident to the licensed social worker (LSW)-A immediately on the morning of 8/17/21. CN-A indicated the nature of the incident required immediate reporting due to the potential of physical harm and stated the LSW-A was responsible for reporting to the SA.

On 11/18/21, at 11:40 a.m. LSW-A confirmed the above findings and indicated she was not able to recall why the incident had been reported late to the SA. LSW-A stated she believed the initial report had been completed by the administrator and could not remember if the incident had been reported to her or not. LSW-A indicated the usual process was for staff to ensure the resident was safe and report any allegations of abuse to the administrator immediately. LSW-A stated the administrator was expected to file the report within two hours to the SA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(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 4	F 609		

Emotional/mental abuse:

Review of a untitled interview sheet on 8/2/21, at 3:00 p.m. the director of nursing (DON) interviewed HK-A regarding an incident involving R2 and NA-A. HK-A indicated NA-A was holding a baby doll in front of R2 and was throwing the doll up in the air. R2 thought the baby doll was real and yelled at NA-A to stop doing that. HK-A indicated NA-A stopped and went to hand the baby doll to R2. HK-A indicated when R2 reached out for the baby doll, NA-A intentionally dropped the doll on the floor and R2 yelled at NA-A "no, no why would you do that, what the hells wrong with you".

Review of the Nursing Home Incident Report #343332 submitted to the SA identified emotional/mental abuse occurred when HK-A reported NA-A threw a baby doll up in the air and proceeded to drop the doll purposely on the floor. R2 had become angry and upset as R2 appeared to believe the doll was a real baby. The report identified the incident occurred on 8/1/21, with no time identified. The incident was reported to the SA on 8/2/21, at 7:21 p.m. The incident was not reported to the SA on 8/1/21, when the allegation of emotional/mental abuse actually was witnessed by HK-A and was not reported until the next day on 8/2/21.

On 11/17/21, at 10:56 a.m. HK-A indicated she walked by the dining room area, when she observed NA-A sitting at the dining room table holding a baby doll by the head and was shaking the baby doll. HK-A stated it was apparent R2 was upset due to the distressed look she gave NA-A. The second time she walked by the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(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 5	F 609		

room area, NA-A was shaking the doll and dropped it on the floor in front of R2. HK-A said NA-A picked the doll up off the floor and R2 made a comment like "what the hell are you thinking or doing". HK-A indicated a few days later she reported the incident to the DON. HK-A stated the incident occurred on a weekend day around 10:30 a.m. or 11:00 a.m. HK-A indicated she was not aware of who to report allegations of abuse to until she spoke with a co-worker the next day. HK-A indicated the DON informed her she should have reported the incident immediately and HK-A confirmed she had not.

On 11/18/21, at 11:16 p.m. LSW-A confirmed the above findings and indicated she was notified of the incident on 8/2/21, during morning report. LSW-A indicated the incident was brought to the DON's attention at the end of the day on 8/2/21. LSW-A stated the information about the incident had been confusing to follow and as a result she was not sure of the exact time the notifications were made. LSW-A confirmed staff should have reported the incident immediately after it had occurred.

On 11/18/21, at 12:17 p.m. the administrator confirmed the above findings and indicated the facility's usual process was for staff to report any allegations of abuse immediately to the charge nurse. The administrator stated the charge nurse was expected to immediately contact the administrator, DON or the LSW and a report was expected to be made within two hours to the SA. The administrator indicated she expected staff to follow the facility policy and to report any allegations of abuse to her immediately and to the SA within two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(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 6 Review of the facility's policy titled, Vulnerable Adult Protection/Neglect Plan revised 2/1/19, indicated all alleged violations involving abuse, should have been reported, to the administrator and other officials (SA) immediately but no later than two hours after forming the suspicion, if the events that caused the suspicion resulted in serious bodily injury or abuse.	F 609		

Electronically delivered
November 30, 2021

Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

Re: State Nursing Home Licensing Orders
Event ID: DGPJ11

Dear Administrator:

The above facility was surveyed on November 17, 2021 through November 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
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 11/17/21, to 11/18/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaints were found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
2 000	Continued From page 1 UNSUBSTANTIATED: H5402024C (MN00077490). H5402026C (MN00075457). The following complaints were found to be SUBSTANTIATED: H5402025C (MN00075924) however, a related licensing order was issued at S1980. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	21980		1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
21980	Continued From page 3 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State Agency (SA) an allegation of physical and mental/emotional abuse no later than 2 hours, for 1 of 3 residents (R2) who was reviewed for abuse. Findings include: Physical abuse: R2's quarterly Minimum Data Set (MDS) dated 9/29/21, indicated R2 was severely cognitively impaired and had diagnoses which included: Alzheimer's, depression and muscle weakness.	21980	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
21980	Continued From page 4 The MDS identified R2 required extensive assistance of one staff with all ADL's. R2's care plan revised on 9/29/21, indicated R2 was vulnerable related to nursing home placement, physical limitations, and sensory impairments. The care plan instructed staff to refer to vulnerability assessment. Review of R2's Vulnerability /Risk Assessment dated 1/26/21, identified R2 was significantly at risk for potentially being abused by another person. Review of R2's progress note dated 8/17/21, indicated LPN-A was in the dining room completing the medication administration task when she heard a resident loudly say "ouch". LPN-A noted R3 quickly wheeled away from the dining room table where the sound came from. LPN-A questioned R3 about the incident and R3 stated," I pinched her (R2) because she was talking about me and I am sick of it". LPN-A approached R2, assessed her for injuries and asked R2 about the situation. Review of the Nursing Home Incident Report #343570 submitted to the SA identified physical abuse (pinching) occurred when R2 was seated in her wheelchair at the dining room table waiting for breakfast and R3 approached R2 in her wheelchair and R2 said "ouch". LPN-A approached the dining room table to investigate what had happened when R3 was observed to wheel away in her wheelchair. R2 informed LPN-A R3 had pinched her. LPN-A asked R3 about the incident and R3 indicated she was tired of R2 talking about her and she confirmed she had pinched her. The report identified the incident occurred on 8/17/21, at 7:40 a.m. and was	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
21980	Continued From page 5	21980		

reported to the SA on 8/17/21, at 4:03 p.m. over eight hours and 23 minutes after the incident had been reported by staff.

On 11/17/21, at 1:08 p.m. LPN-A confirmed R2 was seated in her wheelchair in the dining room when LPN-A overheard R2 say "ouch". LPN-A looked up and observed R3 wheeling herself quickly out of the dining room area. LPN-A indicated when she questioned R3 about the incident, R3 said she pinched R2 because "she was talking about me and I'm sick of it". LPN-A indicated when she asked R2 about the incident, R2 verified R3 had pinched her and stated, "I wish I could pinch her back". LPN-A stated she reported the incident immediately to the charge nurse (CN)-A. LPN-A indicated she was not able to recall the day it happened however remembered the incident occurred around 7:00 a.m.

On 11/18/21, at 9:36 a.m. CN-A confirmed LPN-A reported the allegation of physical abuse involving R3 pinching R2 to her. CN-A verified she had reported the incident to the licensed social worker (LSW)-A immediately on the morning of 8/17/21. CN-A indicated the nature of the incident required immediate reporting due to the potential of physical harm and stated the LSW-A was responsible for reporting to the SA.

On 11/18/21, at 11:40 a.m. LSW-A confirmed the above findings and indicated she was not able to recall why the incident had been reported late to the SA. LSW-A stated she believed the initial report had been completed by the administrator and could not remember if the incident had been reported to her or not. LSW-A indicated the usual process was for staff to ensure the resident was safe and report any allegations of abuse to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
21980	Continued From page 6	21980		

administrator immediately. LSW-A stated the administrator was expected to file the report within two hours to the SA.

Emotional/mental abuse:

Review of a untitled interview sheet on 8/2/21, at 3:00 p.m. the director of nursing (DON) interviewed HK-A regarding an incident involving R2 and NA-A. HK-A indicated NA-A was holding a baby doll in front of R2 and was throwing the doll up in the air. R2 thought the baby doll was real and yelled at NA-A to stop doing that. HK-A indicated NA-A stopped and went to hand the baby doll to R2. HK-A indicated when R2 reached out for the baby doll, NA-A intentionally dropped the doll on the floor and R2 yelled at NA-A "no, no why would you do that, what the hells wrong with you".

Review of the Nursing Home Incident Report #343332 submitted to the SA identified emotional/mental abuse occurred when HK-A reported NA-A threw a baby doll up in the air and proceeded to drop the doll purposely on the floor. R2 had become angry and upset as R2 appeared to believe the doll was a real baby. The report identified the incident occurred on 8/1/21, with no time identified. The incident was reported to the SA on 8/2/21, at 7:21 p.m. The incident was not reported to the SA on 8/1/21, when the allegation of emotional/mental abuse actually was witnessed by HK-A and was not reported until the next day on 8/2/21.

On 11/17/21, at 10:56 a.m. HK-A indicated she walked by the dining room area, when she observed NA-A sitting at the dining room table holding a baby doll by the head and was shaking the baby doll. HK-A stated it was apparent R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
21980	Continued From page 7 was upset due to the distressed look she gave NA-A. The second time she walked by the dining room area, NA-A was shaking the doll and dropped it on the floor in front of R2. HK-A said NA-A picked the doll up off the floor and R2 made a comment like "what the hell are you thinking or doing". HK-A indicated a few days later she reported the incident to the DON. HK-A stated the incident occurred on a weekend day around 10:30 a.m. or 11:00 a.m. HK-A indicated she was not aware of who to report allegations of abuse to until she spoke with a co-worker the next day. HK-A indicated the DON informed her she should have reported the incident immediately and HK-A confirmed she had not. On 11/18/21, at 11:16 p.m. LSW-A confirmed the above findings and indicated she was notified of the incident on 8/2/21, during morning report. LSW-A indicated the incident was brought to the DON's attention at the end of the day on 8/2/21. LSW-A stated the information about the incident had been confusing to follow and as a result she was not sure of the exact time the notifications were made. LSW-A confirmed staff should have reported the incident immediately after it had occurred. On 11/18/21, at 12:17 p.m. the administrator confirmed the above findings and indicated the facility's usual process was for staff to report any allegations of abuse immediately to the charge nurse. The administrator stated the charge nurse was expected to immediately contact the administrator, DON or the LSW and a report was expected to be made within two hours to the SA. The administrator indicated she expected staff to follow the facility policy and to report any allegations of abuse to the SA within two hours.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00474	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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) COMPLETE DATE
21980	Continued From page 8 Review of the facility's policy titled, Vulnerable Adult Protection/Neglect Plan revised 2/1/19, indicated all alleged violations involving abuse, should have been reported, to the SA immediately but no later than two hours after forming the suspicion, if the events that caused the suspicion resulted in serious bodily injury or abuse. SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review the facility polices in regards to reporting of allegations of mistreatment to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21980		