DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2022

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

RE: CCN: 245402
Cycle Start Date: March 7, 2022

Dear Administrator:

On March 7, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 31, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 31, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 31, 2022

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.

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 March 31, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Glenwood Village Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 31, 2022. 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 September 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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March 16, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: VXLU11

Dear Administrator:

The above facility was surveyed on March 3, 2022 through March 7, 2022 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:

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

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
	245402	A. BUILDING _____ B. WING _____	C 03/07/2022

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 3/3/22 through 3/7/22, a complaint survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5402028C (MN80929), with a deficiency cited at F760. In addition, as a result of the investigation a deficiency was also cited at F773. 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 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow physician's orders for 1 of 3	F 760	F760 - Corrective action will be accomplished	3/29/22

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

Electronically Signed | 03/25/2022

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F 760	Continued From page 1 residents (R1), when R1's medication change was omitted for 7 days. This resulted in harm when R1 was hospitalization and had a decline in activities of daily living (ADLs) as a result of the error. Findings include: R1's significant change Minimal Data Set (MDS) dated 11/23/21, indicated R1's diagnoses included heart failure, hypertension, and renal failure. Further review of MDS indicated R1 had no cognitive impairments and required extensive assistance by one staff member for activities of daily living (ADLs) such as bed transfers, ambulation, dressing and toileting. Review of facility report to the State Agency (SA) dated 2/10/22, indicated R1 received an order on 2/3/22, with medication changes. The order was omitted and not processed. R1 received a basic metabolic panel (BMP) lab on 2/8/21, which revealed increased levels. Review of facility's 5-day investigation to the SA dated 2/15/22, indicated a FAX was sent to R1's doctor on 1/23/22, to update on increased blood pressure. Facility received order from doctor on 2/3/22, with medication changes for R1 decreasing Lisinopril and adding Spirolactone as well as a lab order for a BMP after increasing the medication regimen. Registered nurse (RN)-A and licensed practical nurse (LPN)-A were unable to locate a doctor's signature on the order and placed order under case manager's door. On 2/8/22, R1 had a BMP lab completed and results were faxed to R1's medical doctor (MD). On 2/8/22, R1 reported shortness of breath and weakness. On 2/10/22, facility updated MD on resident condition. MD contact the facility on 2/10/22, regarding BMP lab	F 760	for residents affected by nursing staff assuring orders are placed into resident's medical records correctly to avoid having significant medication errors causing significant harm. - The facility identified other residents of having the potential to be affected by the same deficient practice by assuming all residents have the potential to be affected. All residents are invited to monthly group meeting to discuss concerns. Monitoring medical records will identify need for further education for staff members. - Measures put into place to ensure that the deficient practice will not recur are: o Physician order policy was reviewed and revised. o The current nurses were educated on how to process an order. Video was posted to the desktop computers from 2-16-22 to 2-27-22. Nurses signed off after watching video. DON followed up with nurses to see if they watched the video after. 1 nurse did not complete video but did complete watching the video on 3-5-22. o Order processing was discussed in Nursing department meetings on 3-1-22 and 3-3-22. Video of meeting was uploaded to HCA with the further discussion for nurses who missed the meeting to be completed by o Policy was added to new hire orientation for new nurses. o Orders are to not be removed from Unit Mailbox until ready to process. o If removed and unable to process, the	

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F 760	Continued From page 2 results. On 2/10/22, RN-B found the order from 2/3/22, in the unit's mailbox and brought order to case manager (CM)-A. MD was updated on omitted order from 2/3/22, and MD ordered a chest x-ray due to heart failure and gave the facility verbal order to implement the medication changes. On 2/11/22, R1 went to the clinic for chest x-ray and was returned to the facility and required the use of oxygen later that evening. On 2/12/22, resident was sent to the emergency room and was admitted to the hospital. Review of facility's internal investigation, indicated the order from MD on 2/3/22, was change Lisinopril to 10 mg, add Spironolactone 12.5 mg every morning, and check BMP in three to five days of start. There was a note attached to this order from RN-B indicating the order did not have a MD signature and "I thought I would give it back to you". On 3/3/22, at 2:09 p.m. RN-A indicated on the night shift of 2/3/22, there was an order for a couple blood pressure medications and then a lab order for a BMP left from the evening shift nurses for the night shift to enter. RN-A indicated there was not a signature from the doctor on the order and both LPN-A and RN-A got busy and decided to place the order in the station's mailbox for the case manager to look at. RN-A indicated the licensed staff are expected to process the order and then send it back to the doctor for a signature, however on this night shift due to becoming busy with other residents both LPN-A and RN-A did not have time to process the order. In addition, RN-A indicated the director of nursing (DON) provided education related to the protocol for processing a doctor's order and if the licensed nursing staff is unable to get the order completed	F 760	processing nurse is to update the doctor via fax or phone, place a progress note in the resident's chart and report off order and issue found in 24-hour report. o When the order is completed, the order is to go into the resident's chart to be handed over to the next nurse to 2nd sign. - The facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by: o DON or designee will verify compliance with auditing new medical records for 14 days, then weekly for 4 weeks, then monthly for 3 months to gather appropriate data to ensure staff have corrected the concern or if the further education would be required. o Results of audits will be discussed at next QAPI committee to determine compliance or the need for continued monitoring. - The date the deficiency will be corrected by is 3/29/2022. - Person Responsible: DON	

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F 760	Continued From page 3	F 760		

then they are directed to put the order in the file folder for the case manager assigned to the unit. In addition, action taken to prevent reoccurrence to resident and others included educating all licensed staff on Physician Orders policy.

On 3/3/22, at 2:28 p.m. family member (FM)-A indicated R1 was hospitalized on 2/12/22, due to "heart failure exacerbation" which happened quickly. Further, FM-A indicated R1 reported to the facility staff that she felt short of breath (SOB) and staff spoke with R1's primary doctor who then ordered a chest x-ray on 2/11/22. FM-A indicated the chest x-ray showed R1's heart failure was increasing and the next thing she knew R1 was in bad heart failure. In addition, FM-A indicated since R1's return to the facility following this hospitalization, R1 is not ambulating and requiring a mechanical lift for transfers.

On 3/3/22, at 4:29 p.m. observed nursing assistant (NA)-A and case manager (CM)-A assisting R1 into the bathroom utilizing a mechanical standing lift.

On 3/3/22, at 4:37 p.m. NA-A indicated R1 was able to ambulate with a walker prior to recent hospitalization and is now requiring a mechanical standing lift for transfers.

On 3/4/22, at 8:02 a.m. LPN-A indicated it was approximately 3:00 a.m. during her shift on 2/3/22, and noticed RN-A had a lot of call lights going off so LPN-A asked to assist. LPN-A indicated she was unable to find a doctor's signature on the order for R1's medication changes and notified RN-A. Further, LPN-A stated she was "still not privy" on the facility's protocol for processing orders and what she is

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F 760	Continued From page 4	F 760		

expected to do if she cannot find a doctor's signature on the order. In addition, LPN-A confirmed since R1's hospitalization she requires the use of stand mechanical lift due to weakness.

On 3/4/22, at 8:53 a.m. RN-B indicated on 2/12/22, R1 was noted to report SOB and having a hard time breathing to the nursing staff. R1 was provided a nebulizer and oxygen which showed no improvements. R1 transferred to the emergency room to be further evaluated. RN-B indicated she was admitted to the hospital for congestive heart failure exacerbation and was there a few days. RN-B indicated upon returning to the facility, R1 now requires the use of a mechanical stand lift for transfers due to weakness.

On 3/4/22, at 9:25 a.m. when asked what the facility's policy was regarding processing physician orders, CM-A indicated if staff were unsure or something was missing, the order would then get passed onto the case manager or the oncoming nurse. Further, CM-A indicated the night nursing staff do not typically process orders, especially if there were clarifications needed. CM-A indicated on 2/3/22, when the order for medication changes was received RN-A and LPN-A reviewed the order and it got late and they were unsure what to do with it, so they left the order with a note in the mailboxes. Further, CM-A indicated there was a 7-day delay by the time the order with the note attached was given to CM-A. CM-A indicated she was unsure where the order was for the week but "seemed like a neglect situation especially with a person so fragile as [R1] is". CM-A updated R1's MD on 2/10/22, and MD ordered to implement the medication changes. The medication changes were ordered

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F 760	Continued From page 5	F 760		

and started on 2/12/22. On 2/12/22, R1 reported she felt SOB, and her oxygen stats were dropping, and she was getting anxious. R1 was sent to the emergency room and admitted to the hospital with heart failure. In addition, CM-A indicated since R1 had returned from hospital she is requiring a mechanical stand lift for transfers, does not ambulate anymore, and is more deconditioned.

On 3/4/22, at 12:09 p.m. director of nursing (DON) indicated R1's hospitalization could have been delayed if the medication changes ordered on 2/3/22, would have been implemented timely. Further, DON indicated the medication changes would have assisted to help R1's blood pressures and take away fluid. DON indicated licensed nursing staff were educated on facility's Physician Orders policy which included how to process an order. DON confirmed there was one licensed nurse who worked on the floor on 3/3/22, who had not completed the education at this time.

On 3/8/22, at 12:09 p.m. interview with MD and clinic nurse (CN)-A indicated the lack of implementation of R1's medication changes ordered on 2/3/22, could have contributed to R1's hospitalization on 2/12/22.

Review of facility policy titled Physician Orders revised 2/12/22, directed staff as follows: orders are taken by a licensed nursing staff (RN or LPN), orders are given by a medical doctor, physician assistant, or nurse practitioner, orders which are received by phone or FAX must include date and time, check for a doctor signature and if there is not a signature enter the order as a verbal/telephone order. Further review of policy directs licensed nursing staff to make a note on

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	245402	A. BUILDING _____ B. WING _____	C 03/07/2022

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 760	Continued From page 6 the 24-hour report sheet that there is anew order and where it is, report to the on-coming charge nurse the new order, document in resident record with progress note, pass order to a second licensed nurse to double check input into records is correct. In addition, the facility policy directs licensed nursing staff if the order is missing any information contact the medical doctor for clarification and progress note the issue found, document on 24-hour report sheet and pass off on shift change.	F 760		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician orders for weekly basic metabolic panel (BMP) labs were followed as written for 1 of 3 residents (R1). Findings include: R1's significant change Minimal Data Set (MDS) dated 11/23/21, indicated R1's diagnoses	F 773	F773 - Corrective action will be accomplished for residents affected by nursing staff assuring laboratory orders are processed and implemented correctly. - The facility identified other residents of having the potential to be affected by the same deficient practice by assuming all residents have the potential to be	3/29/22

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F 773	Continued From page 7 included heart failure, hypertension, and renal failure. Further review of MDS indicated R1 had no cognitive impairments and required extensive assistance by one staff member for activities of daily living (ADLs) such as bed transfers, ambulation, dressing and toileting. R1's care plan dated 11/24/21, indicated R1 had renal insufficiency related to chronic kidney disease, hypertensive heart disease with chronic kidney failure and atherosclerosis of renal artery which direct staff to monitor lab reports of electrolytes and report to physician. R1's physician's orders dated 12/14/21, indicated BMP labs every Tuesday for chronic kidney disease with no end date. Review of R1's BMP labs are as follows: 12/14/21, 1/18/22 and 2/9/22 which all revealed high creatine and bun levels. R1's medical record lacked evidence of weekly BMP labs for the following dates: 12/21/21, 12/28/21, 1/4/22, 1/11/22, 1/25/22, and 2/1/22. On 3/7/22, at 11:22 a.m. when asked where R1's weekly BMP labs were located in R1's record, case manager (CM)-A confirmed the labs have not been obtained. CM-A indicated staff were expected to process the order from the physician and call the lab to set up lab draw. CM-A calls the lab and indicated the doctor ordered a weekly BMP and she was curious as to why the lab was not getting drawn every week as ordered. In addition, CM-A was unsure what happened with R1's weekly lab draws being missed. On 3/7/22, at 9:12 a.m. clinic nurse (CN) confirmed the MD received BMP labs from the	F 773	affected. Auditing of laboratory orders in current resident's medical records implemented. Auditing of medical record orders implemented from Tag F 760. - Measures put into place to ensure that the deficient practice will not recur are: o Review of Procedure completed with GRHS laboratory on how they implement GRV's orders. o Procedure of how to process lab orders updated with Title, Date, Logo and what the order Template for entering the lab order into PCC is called. o Education to Licensed staff on processing laboratory orders. - The facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by: o Review of active resident's lab orders for the past 30 days. If labs are in question, clarification will be obtained. o Review of current labs to be processed in the next thirty days reviewed with GRHS lab. o The fax from Lab with the List of lab draws collected and compared to list of laboratory draws in the computer audited weekly for 4 weeks and then monthly for 2 months and then quarterly. o Results of audits will be discussed at next QAPI committee to determine compliance or the need for continued monitoring. - The date the deficiency will be corrected by is 3/29/2022. Responsible person: DON	

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F 773	Continued From page 8	F 773		

facility on 12/14/21, which was the date of the initial order, 1/3/22, 1/18/22, and there were no other weekly BMP labs sent again until 2/9/22.

On 3/7/22, at 4:08 p.m. director of nursing indicated she was made aware of R1's weekly BMP lab draws order not being followed consistently on 3/7/22. DON indicated staff were expected to enter the order into the computer if they are weekly and call the order into the lab. In addition, DON was unsure what caused R1's weekly BMP labs to be missed or why the labs were ordered.

On 3/8/22, at 12: 09 p.m. interview with medical doctor (MD) and CN indicated the facility staff had not been consistent with R1's weekly BMP labs as ordered and have not been keeping MD updated. Further, MD and CN indicated there was an order for weekly BMP labs in their communication to the facility staff beginning on 12/14/21, however for a few weeks the facility was following the order correctly and then missed it for a few weeks. In addition, MD and CN indicated R1's weekly BMP labs were important due to R1's increase in blood pressures and additions of blood pressure medications which can cause electrolyte imbalances, decreases in sodium and potassium when can lead to "devastating effects" to the body.

Requested lab order policy from facility, however facility failed to provide a policy but provided a word document containing no title or date that contained the following: When order is received for a lab staff are directed to place order in Electronic Record under Laboratory order, call Lab at 320-634-5717, report Lab order as written (name, date of birth, frequency, diagnosis;

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F 773	Continued From page 9 physician) and check mark on order reference stamp next to lab. Review of facility policy titled Physician Orders revised 2/12/22, directed staff to notify appropriate department if it is not a medication order such as lab work. Staff were expected to notify lab and put the date in the calendar when lab is coming and add lab orders to treatment record.	F 773		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2022

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

RE: CCN: 245402
Cycle Start Date: March 7, 2022

Dear Administrator:

On March 7, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 31, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 31, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 31, 2022

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.

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 March 31, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Glenwood Village Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 31, 2022. 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 September 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: VXLU11

Dear Administrator:

The above facility was surveyed on March 3, 2022 through March 7, 2022 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:

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

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

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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 3/3/22 through 3/7/22, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5402028C (MN80929) with a licensing order issued at 1545. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		3/29/22

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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
21545	Continued From page 3 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow physician's orders for 1 of 3 residents (R1), when R1's medication change was omitted for 7 days. This resulted in harm when R1 was hospitalization and had a decline in activities of daily living (ADLs) as a result of the error. Findings include: R1's significant change Minimal Data Set (MDS) dated 11/23/21, indicated R1's diagnoses included heart failure, hypertension, and renal failure. Further review of MDS indicated R1 had no cognitive impairments and required extensive assistance by one staff member for activities of daily living (ADLs) such as bed transfers, ambulation, dressing and toileting. Review of facility report to the State Agency (SA) dated 2/10/22, indicated R1 received an order on 2/3/22, with medication changes. The order was	21545	Corrected	

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21545	Continued From page 4	21545		

omitted and not processed. R1 received a basic metabolic panel (BMP) lab on 2/8/21, which revealed increased levels. Review of facility's 5-day investigation to the SA dated 2/15/22, indicated a FAX was sent to R1's doctor on 1/23/22, to update on increased blood pressure. Facility received order from doctor on 2/3/22, with medication changes for R1 decreasing Lisinopril and adding Spirolactone as well as a lab order for a BMP after increasing the medication regimen. Registered nurse (RN)-A and licensed practical nurse (LPN)-A were unable to locate a doctor's signature on the order and placed order under case manager's door. On 2/8/22, R1 had a BMP lab completed and results were faxed to R1's medical doctor (MD). On 2/8/22, R1 reported shortness of breath and weakness. On 2/10/22, facility updated MD on resident condition. MD contact the facility on 2/10/22, regarding BMP lab results. On 2/10/22, RN-B found the order from 2/3/22, in the unit's mailbox and brought order to case manager (CM)-A. MD was updated on omitted order from 2/3/22, and MD ordered a chest x-ray due to heart failure and gave the facility verbal order to implement the medication changes. On 2/11/22, R1 went to the clinic for chest x-ray and was returned to the facility and required the use of oxygen later that evening. On 2/12/22, resident was sent to the emergency room and was admitted to the hospital.

Review of facility's internal investigation, indicated the order from MD on 2/3/22, was change Lisinopril to 10 mg, add Spironolactone 12.5 mg every morning, and check BMP in three to five days of start. There was a note attached to this order from RN-B indicating the order did not have a MD signature and "I thought I would give it back to you".

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21545	Continued From page 5 On 3/3/22, at 2:09 p.m. RN-A indicated on the night shift of 2/3/22, there was an order for a couple blood pressure medications and then a lab order for a BMP left from the evening shift nurses for the night shift to enter. RN-A indicated there was not a signature from the doctor on the order and both LPN-A and RN-A got busy and decided to place the order in the station's mailbox for the case manager to look at. RN-A indicated the licensed staff are expected to process the order and then send it back to the doctor for a signature, however on this night shift due to becoming busy with other residents both LPN-A and RN-A did not have time to process the order. In addition, RN-A indicated the director of nursing (DON) provided education related to the protocol for processing a doctor's order and if the licensed nursing staff is unable to get the order completed then they are directed to put the order in the file folder for the case manager assigned to the unit. In addition, action taken to prevent reoccurrence to resident and others included educating all licensed staff on Physician Orders policy. On 3/3/22, at 2:28 p.m. family member (FM)-A indicated R1 was hospitalized on 2/12/22, due to "heart failure exacerbation" which happened quickly. Further, FM-A indicated R1 reported to the facility staff that she felt short of breath (SOB) and staff spoke with R1's primary doctor who then ordered a chest x-ray on 2/11/22. FM-A indicated the chest x-ray showed R1's heart failure was increasing and the next thing she knew R1 was in bad heart failure. In addition, FM-A indicated since R1's return to the facility following this hospitalization, R1 is not ambulating and requiring a mechanical lift for transfers. On 3/3/22, at 4:29 p.m. observed nursing assistant (NA)-A and case manager (CM)-A	21545		

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21545	Continued From page 6	21545		

assisting R1 into the bathroom utilizing a mechanical standing lift.

On 3/3/22, at 4:37 p.m. NA-A indicated R1 was able to ambulate with a walker prior to recent hospitalization and is now requiring a mechanical standing lift for transfers.

On 3/4/22, at 8:02 a.m. LPN-A indicated it was approximately 3:00 a.m. during her shift on 2/3/22, and noticed RN-A had a lot of call lights going off so LPN-A asked to assist. LPN-A indicated she was unable to find a doctor's signature on the order for R1's medication changes and notified RN-A. Further, LPN-A stated she was "still not privy" on the facility's protocol for processing orders and what she is expected to do if she cannot find a doctor's signature on the order. In addition, LPN-A confirmed since R1's hospitalization she requires the use of stand mechanical lift due to weakness.

On 3/4/22, at 8:53 a.m. RN-B indicated on 2/12/22, R1 was noted to report SOB and having a hard time breathing to the nursing staff. R1 was provided a nebulizer and oxygen which showed no improvements. R1 transferred to the emergency room to be further evaluated. RN-B indicated she was admitted to the hospital for congestive heart failure exacerbation and was there a few days. RN-B indicated upon returning to the facility, R1 now requires the use of a mechanical stand lift for transfers due to weakness.

On 3/4/22, at 9:25 a.m. when asked what the facility's policy was regarding processing physician orders, CM-A indicated if staff were unsure or something was missing, the order would then get passed onto the case manager or

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21545	Continued From page 7	21545		

the oncoming nurse. Further, CM-A indicated the night nursing staff do not typically process orders, especially if there were clarifications needed. CM-A indicated on 2/3/22, when the order for medication changes was received RN-A and LPN-A reviewed the order and it got late and they were unsure what to do with it, so they left the order with a note in the mailboxes. Further, CM-A indicated there was a 7-day delay by the time the order with the note attached was given to CM-A. CM-A indicated she was unsure where the order was for the week but "seemed like a neglect situation especially with a person so fragile as [R1] is". CM-A updated R1's MD on 2/10/22, and MD ordered to implement the medication changes. The medication changes were ordered and started on 2/12/22. On 2/12/22, R1 reported she felt SOB, and her oxygen stats were dropping, and she was getting anxious. R1 was sent to the emergency room and admitted to the hospital with heart failure. In addition, CM-A indicated since R1 had returned from hospital she is requiring a mechanical stand lift for transfers, does not ambulate anymore, and is more deconditioned.

On 3/4/22, at 12:09 p.m. director of nursing (DON) indicated R1's hospitalization could have been delayed if the medication changes ordered on 2/3/22, would have been implemented timely. Further, DON indicated the medication changes would have assisted to help R1's blood pressures and take away fluid. DON indicated licensed nursing staff were educated on facility's Physician Orders policy which included how to process an order. DON confirmed there was one licensed nurse who worked on the floor on 3/3/22, who had not completed the education at this time.

On 3/8/22, at 12:09 p.m. interview with MD and

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21545	Continued From page 8 clinic nurse (CN)-A indicated the lack of implementation of R1's medication changes ordered on 2/3/22, could have contributed to R1's hospitalization on 2/12/22. Review of facility policy titled Physician Orders revised 2/12/22, directed staff as follows: orders are taken by a licensed nursing staff (RN or LPN), orders are given by a medical doctor, physician assistant, or nurse practitioner, orders which are received by phone or FAX must include date and time, check for a doctor signature and if there is not a signature enter the order as a verbal/telephone order. Further review of policy directs licensed nursing staff to make a note on the 24-hour report sheet that there is anew order and where it is, report to the on-coming charge nurse the new order, document in resident record with progress note, pass order to a second licensed nurse to double check input into records is correct. In addition, the facility policy directs licensed nursing staff if the order is missing any information contact the medical doctor for clarification and progress note the issue found, document on 24-hour report sheet and pass off on shift change. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders. The DON or designee could verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be	21545		

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21545	Continued From page 9 required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		