Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2025

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

RE: CCN: 245402
Cycle Start Date: January 10, 2025

Dear Administrator:

On January 27, 2025, we notified you a remedy was imposed. On February 11, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 28, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 11, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 27, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 11, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 28, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered

February 18, 2025

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

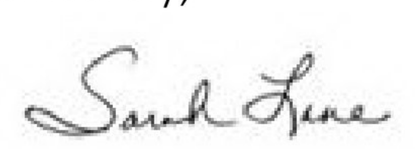
Re: Reinspection Results
Event ID: U70912

Dear Administrator:

On February 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Electronically delivered
January 27, 2025

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

RE: CCN: 245402
Cycle Start Date: January 10, 2025

Dear Administrator:

On January 10, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 11, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 11, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 11, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 11, 2025, 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 February 11, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 10, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: U70911

Dear Administrator:

The above facility was surveyed on January 9, 2025, through January 10, 2025, 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, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING _____ B. WING _____	C 01/10/2025

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 1/9/25 through 1/10/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H54024481C (MN00109700) with a deficiency issued at F689. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer's	F 689	Plan of Correction – F689	1/28/25

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

Electronically Signed | 01/28/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

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F 689	Continued From page 1 guidelines for a full body mechanical lift by ensuring the loops were secured to the hook on the lift, prior to lifting the resident for transfer for 1 of 3 residents (R1) reviewed. This resulted in actual harm when the hook came off the lift and R1 fell to the floor sustaining a large hematoma to the side of his head, a skin tear to finger and required an emergency department (ED) visit. Findings include: R1's care plan dated 6/15/23, indicated R1 had impaired functional status related to hemiparesis, history of stroke and had limited ability to complete activities of daily living (ADLs), dependent on staff for assistance, and utilized a wheelchair and mechanical lift. Further, R1's care plan identified R1 was dependent on staff for transfers with a mechanical lift and assist of two. R1's Fall-Witnessed incident report dated 1/7/25, indicated R1 was being transferred from the tub chair to the bed by two staff members with a Hoyer lift (full body lift). The Top right corner of the sling came off the lift and R1 fell towards the floor. R1 hit the floor with the top right side of his head. R1 was assessed for injury and vitals were obtained. R1 was hypertensive and R1 was wheezing at the time, was short of breath, and had a large hematoma on the right side of his head and skin tear to right fingers. At the time of the incident, R1 had reported 10/10 pain. R1 was sent to the ED. R1's progress note dated 1/9/25, registered nurse (RN) post fall follow up indicated R1 had sustained a skin tear to right fifth digit and a hematoma to right temple. R1 denied pain to area of trauma on the head and pain to the right	F 689	1. Address how the facility will correct the deficiency as it relates to the individual. NA - A and NA - B, were immediately educated on incident and proper protocol for transferring a resident using a full body lift. NA-A and NA-B, were provided with further training on mechanical lifts and provided a competency check. Audits have been performed on R1 to ensure proper protocol is being followed. 2. Address how the facility will act to protect residents in similar situations. All residents had the potential to be affected. All lifts and lift sheets were inspected to ensure proper functioning. Full facility staff education for EZ - Way lifts was performed with competency. All new staff will be assigned EZ – way lift training with competency. EZ way lift policy was reviewed to ensure accuracy. 3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. Transfer audits were performed for R1 following the incident. Audits will be completed on resident transfers who use EZ- way full body lifts. Any issues will be discussed with the IDT and brought to QAPI. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

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F 689	Continued From page 2 hand/finger skin tear. Contributing factors related to R1's fall were identified as R1 had returned to his room following a bath. The lift sling was under him, and staff proceeded to hook R1 up to the mechanical lift and then called for assistance. The second aide came into the room and took the control to lift R1 with the lift and did not double check to ensure he was hooked up properly. Immediate education was provided to the staff involved on double checking the lift sheet before lifting the resident. Other interventions included lift sheet was checked and was the right size with no rips or tears, education with competency on lifts was completed for the aides involved in the incident. R1's ED Transfer Report dated 1/7/25, indicated per assessment R1 had a fall from Hoyer approximately 3-4 feet and had complaints of a headache and neck pain, and R1's blood pressure was noted to be 163/95. Discharge note revealed computed tomography (CT) imaging of R1's head, facial bones, and cervical spine did not show any evidence of bleeding within the skull, he did have a large hematoma on the right side of his head. There was no facial hone fractures or neck fracture. R1's labs were stable. R1 was given a gram of IV Tylenol during his evaluation, and his pain appeared to be improved. On 1/9/25 at 1:23 p.m., R1 was sitting in his wheelchair in his room and appeared to be comfortable. R1 had a red spot on the right side of his head that did not appear to be an open wound and a Band-Aid was on his right pinky finger. R1 denied pain to the areas. R1 stated he could not recall the incident but stated "they were banging me on the Hoyer".	F 689	Audits will be completed on all residents who use full body lifts weekly x 4 weeks, then monthly x 3 months, then randomly following that. 5. The plan of correction must provide dates when corrective action will be completed. January 28th, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 3 On 1/9/25 at 1:33 p.m. licensed practical nurse (LPN)-A stated R1 was totally dependent on staff for all ADLs due to left sided weakness, and R1 required assistance of two staff members for transfers using a Hoyer mechanical lift. LPN-A stated on 1/7/25 at approximately 12:50 p.m., she was standing outside of R1's room at her medication cart when she heard someone scream and then entered R1's room. LPN-A stated R1 was on the floor and LPN-A noted a large hematoma to the right side of R1's head that appeared to look like a rug burn and R1's head was "hit hard". LPN-A assessed and determined staff could safely transfer him into bed, and LPN-A then noted the skin tear to his finger which was bleeding. LPN-A called the ambulance and R1 was sent to the ED. Further, LPN-A stated at the ED, R1 had received IV Tylenol for pain and a CT, and X-rays were obtained of R1's head and neck which came back normal. LPN-A stated since the incident, R1 had returned to his baseline and at times has had complaints of pain to his head which was treated with ice and elevating his head. In addition, LPN-A stated the two nursing assistants (NA) involved had both been re-educated immediately to double check the lift to ensure the hooks were properly secured prior to lifting the resident. LPN-A stated all staff education had not been provided due to the director of nursing (DON) being out of the facility at the time. On 1/9/25 at 2:00 p.m., NA-A stated R1 was totally dependent on staff with all ADLs and required assistance of two staff for transfers with a Hoyer lift. NA-A stated on 1/7/25, at approximately 1:00 p.m., she had assisted R1 with a bath and back to his room where she	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

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F 689	Continued From page 4	F 689		

hooked R1's sling to the Hoyer and then called for assistance to transfer. NA-A stated NA-B entered the room, and she began controlling the mechanical lift and lifted R1 up off the tub chair. NA-A stated R1 was approximately 3 feet in the air when he suddenly dropped onto the floor and hit his head. NA-A stated R1 appeared to be in pain following the incident and was sent to the ED. Further, NA-A stated she was unsure what caused R1 to fall however stated she was not sure if staff were to secure the loop to the lift or just set it on top of the bar however, confirmed NA-B did not double check the loops prior to lifting R1. In addition, NA-A stated facility protocol for a mechanical lift was to always use two staff with the lift transfers, both staff were expected to hook the sling to the lift, double check to ensure the loops were secure properly to the lift prior to lifting the resident. NA-A stated she was immediately educated on the process following the incident and had further training regarding the mechanical lifts and a competency check on 1/9/25.

On 1/9/25 at 2:12 p.m., NA-B stated R1 required assist of two staff for transfers with a Hoyer lift and assistance with all other ADLs. NA-B stated on 1/7/25, some time after noon meal, NA-B was called to R1's room by NA-A requesting assistance to transfer R1 into his bed following his bath. NA-B stated she entered R1's room, R1 was sitting on the tub chair, Hoyer sling under him and attached to the lift. NA-B stated she began operating the lift and lifted R1 up off the chair, when R1 was in the air the top of the sling came off the bar and R1 tipped out of the sling headfirst onto the floor. NA-B stated following the incident, R1 was joking with staff and there was a bump noted on the side of his head. Further, NA-B

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	245402	A. BUILDING _____ B. WING _____	C 01/10/2025

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F 689	Continued From page 5 confirmed she did not double check to ensure NA-A had properly secured all the loops prior to transferring R1 as required however, stated going forward NA-A would be more careful as the incident taught her a valuable lesson. NA-B stated she was educated following the incident and had a competency check with mechanical lifts. On 1/9/25 at 3:59 p.m., RN-A stated R1 required assist of 2 with transfers utilizing a Hoyer lift and had chronic pain to his left side. RN-A stated on 1/7/25, after the noon meal, NA-A and NA-B had been transferring R1 with the Hoyer and NA-B had not ensured the loops were secured to the lift when they had started lifting R1 and he fell. RN-A believed R1 was more than two feet in the air when he fell. RN-A was notified immediately to come to R1's room by LPN-A. RN-A stated right when she looked at R1, she stated he needed to be sent to the ED immediately. RN-A stated while at the ED, they completed some imaging to rule out any fractures and administered medications for R1's pain. R1 had returned to the facility the same day with no new orders however, staff were monitoring R1's hematoma on his head and cleaned and applied Steri-strips to R1's skin tear on his finger. Further, RN-A stated all Hoyer lift transfers required assistance of two staff, however, one staff could hook the sling to the resident and the second staff should be verify all loops were secured prior to transferring the resident. RN-A stated both NA-s were educated immediately following the incident regarding facility process. In addition, RN-A stated DON and the administrator were both out of the facility and all staff training was to be scheduled for 1/14/25.	F 689		

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F 689	Continued From page 6 On 1/10/25 at 9:45 a.m., LPN-A stated when she entered R1's room on 1/7/24, R1 was "screaming out in pain", however, R1 does have a history of yelling out during cares. LPN-A stated it was obvious however, R1 was in 10/10 pain, and when asked what hurt R1 said his head hurt. On 1/10/25 at 9:52 a.m., NA-B and NA-C entered R1's room with the Hoyer lift due to R1 wanting to be transferred from his wheelchair into his bed. R1 had the Hoyer sling under him already, NA-B and NA-C both hooked the loops to the lift and NA-B then doubled checked all 4 loops. NA-B operated the mechanical lift while NA-C guided R1 to the bed. NA-B lowered R1 onto the bed. On 1/10/25 at 10:18 a.m., NA-C stated she was a contracted agency staff and had been working at the facility for approximately three weeks. NA-C stated R1 required assist of two staff to transfer utilizing the Hoyer lift. NA-C stated she was aware R1 had a fall from the Hoyer lift however, was unsure of the details regarding the incident. NA-C stated for all Hoyer transfers, staff were expected to ensure all 4 loops were secured to the lift prior to transferring resident. Further, NA-C confirmed following R1's fall there has been no education provided to staff regarding mechanical lifts. On 1/10/25 at 11:40 a.m., attempted interview with DON was unsuccessful. Review of EZ Way Smart Lift Operator's Instructions revised 10/24/24, directed staff to make a final check of all four loop attachment points to ensure each loop was sufficiently attached to the respective hook of the hanger bars, and while lifting the patient continue upward	F 689		

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F 689	Continued From page 7 motion until there was tension on the sling legs, make sure all the loops on the sling were securely hooked on the hanger bars. Review of facility policy titled EZ Way Smart Lifts revised 11/2/21, directed staff to check the condition of the sling before every use by checking entire sling for damage or wear including the loops and stitching, and if there were concerns with resident safety while transferring, stop the transfer, get assistance to keep the resident safe while getting the charge nurse. However, the policy did not direct staff to verify the loops were securely hooked prior to lifting the resident.	F 689		

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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 1/9/25 through 1/10/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H54024481C (MN00109700) with a licensing order issued at 0830. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer's guidelines for a full body mechanical lift by ensuring the loops were secured to the hook on the lift, prior to lifting the resident for transfer for 1 of 3 residents (R1) reviewed. This resulted in actual harm when the hook came off the lift and R1 fell to the floor sustaining a large hematoma to the side of his head, a skin tear to finger and required an emergency department (ED) visit.	2 830	Corrected.	1/28/25

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2 830	Continued From page 3 Findings include: R1's care plan dated 6/15/23, indicated R1 had impaired functional status related to hemiparesis, history of stroke and had limited ability to complete activities of daily living (ADLs), dependent on staff for assistance, and utilized a wheelchair and mechanical lift. Further, R1's care plan identified R1 was dependent on staff for transfers with a mechanical lift and assist of two. R1's Fall-Witnessed incident report dated 1/7/25, indicated R1 was being transferred from the tub chair to the bed by two staff members with a Hoyer lift (full body lift). The Top right corner of the sling came off the lift and R1 fell towards the floor. R1 hit the floor with the top right side of his head. R1 was assessed for injury and vitals were obtained. R1 was hypertensive and R1 was wheezing at the time, was short of breath, and had a large hematoma on the right side of his head and skin tear to right fingers. At the time of the incident, R1 had reported 10/10 pain. R1 was sent to the ED. R1's progress note dated 1/9/25, registered nurse (RN) post fall follow up indicated R1 had sustained a skin tear to right fifth digit and a hematoma to right temple. R1 denied pain to area of trauma on the head and pain to the right hand/finger skin tear. Contributing factors related to R1's fall were identified as R1 had returned to his room following a bath. The lift sling was under him, and staff proceeded to hook R1 up to the mechanical lift and then called for assistance. The second aide came into the room and took the control to lift R1 with the lift and did not double check to ensure he was hooked up properly. Immediate education was provided to the staff	2 830		

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2 830	Continued From page 4 involved on double checking the lift sheet before lifting the resident. Other interventions included lift sheet was checked and was the right size with no rips or tears, education with competency on lifts was completed for the aides involved in the incident. R1's ED Transfer Report dated 1/7/25, indicated per assessment R1 had a fall from Hoyer approximately 3-4 feet and had complaints of a headache and neck pain, and R1's blood pressure was noted to be 163/95. Discharge note revealed computed tomography (CT) imaging of R1's head, facial bones, and cervical spine did not show any evidence of bleeding within the skull, he did have a large hematoma on the right side of his head. There was no facial hone fractures or neck fracture. R1's labs were stable. R1 was given a gram of IV Tylenol during his evaluation, and his pain appeared to be improved. On 1/9/25 at 1:23 p.m., R1 was sitting in his wheelchair in his room and appeared to be comfortable. R1 had a red spot on the right side of his head that did not appear to be an open wound and a Band-Aid was on his right pinky finger. R1 denied pain to the areas. R1 stated he could not recall the incident but stated "they were banging me on the Hoyer". On 1/9/25 at 1:33 p.m. licensed practical nurse (LPN)-A stated R1 was totally dependent on staff for all ADLs due to left sided weakness, and R1 required assistance of two staff members for transfers using a Hoyer mechanical lift. LPN-A stated on 1/7/25 at approximately 12:50 p.m., she was standing outside of R1's room at her medication cart when she heard someone scream and then entered R1's room. LPN-A	2 830		

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2 830	Continued From page 5 stated R1 was on the floor and LPN-A noted a large hematoma to the right side of R1's head that appeared to look like a rug burn and R1's head was "hit hard". LPN-A assessed and determined staff could safely transfer him into bed, and LPN-A then noted the skin tear to his finger which was bleeding. LPN-A called the ambulance and R1 was sent to the ED. Further, LPN-A stated at the ED, R1 had received IV Tylenol for pain and a CT, and X-rays were obtained of R1's head and neck which came back normal. LPN-A stated since the incident, R1 had returned to his baseline and at times has had complaints of pain to his head which was treated with ice and elevating his head. In addition, LPN-A stated the two nursing assistants (NA) involved had both been re-educated immediately to double check the lift to ensure the hooks were properly secured prior to lifting the resident. LPN-A stated all staff education had not been provided due to the director of nursing (DON) being out of the facility at the time. On 1/9/25 at 2:00 p.m., NA-A stated R1 was totally dependent on staff with all ADLs and required assistance of two staff for transfers with a Hoyer lift. NA-A stated on 1/7/25, at approximately 1:00 p.m., she had assisted R1 with a bath and back to his room where she hooked R1's sling to the Hoyer and then called for assistance to transfer. NA-A stated NA-B entered the room, and she began controlling the mechanical lift and lifted R1 up off the tub chair. NA-A stated R1 was approximately 3 feet in the air when he suddenly dropped onto the floor and hit his head. NA-A stated R1 appeared to be in pain following the incident and was sent to the ED. Further, NA-A stated she was unsure what caused R1 to fall however stated she was not sure if staff were to secure the loop to the lift or	2 830		

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2 830	Continued From page 6 just set it on top of the bar however, confirmed NA-B did not double check the loops prior to lifting R1. In addition, NA-A stated facility protocol for a mechanical lift was to always use two staff with the lift transfers, both staff were expected to hook the sling to the lift, double check to ensure the loops were secure properly to the lift prior to lifting the resident. NA-A stated she was immediately educated on the process following the incident and had further training regarding the mechanical lifts and a competency check on 1/9/25. On 1/9/25 at 2:12 p.m., NA-B stated R1 required assist of two staff for transfers with a Hoyer lift and assistance with all other ADLs. NA-B stated on 1/7/25, some time after noon meal, NA-B was called to R1's room by NA-A requesting assistance to transfer R1 into his bed following his bath. NA-B stated she entered R1's room, R1 was sitting on the tub chair, Hoyer sling under him and attached to the lift. NA-B stated she began operating the lift and lifted R1 up off the chair, when R1 was in the air the top of the sling came off the bar and R1 tipped out of the sling headfirst onto the floor. NA-B stated following the incident, R1 was joking with staff and there was a bump noted on the side of his head. Further, NA-B confirmed she did not double check to ensure NA-A had properly secured all the loops prior to transferring R1 as required however, stated going forward NA-A would be more careful as the incident taught her a valuable lesson. NA-B stated she was educated following the incident and had a competency check with mechanical lifts. On 1/9/25 at 3:59 p.m., RN-A stated R1 required assist of 2 with transfers utilizing a Hoyer lift and had chronic pain to his left side. RN-A stated on	2 830		

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2 830	Continued From page 7 1/7/25, after the noon meal, NA-A and NA-B had been transferring R1 with the Hoyer and NA-B had not ensured the loops were secured to the lift when they had started lifting R1 and he fell. RN-A believed R1 was more than two feet in the air when he fell. RN-A was notified immediately to come to R1's room by LPN-A. RN-A stated right when she looked at R1, she stated he needed to be sent to the ED immediately. RN-A stated while at the ED, they completed some imaging to rule out any fractures and administered medications for R1's pain. R1 had returned to the facility the same day with no new orders however, staff were monitoring R1's hematoma on his head and cleaned and applied Steri-strips to R1's skin tear on his finger. Further, RN-A stated all Hoyer lift transfers required assistance of two staff, however, one staff could hook the sling to the resident and the second staff should be verify all loops were secured prior to transferring the resident. RN-A stated both NA-s were educated immediately following the incident regarding facility process. In addition, RN-A stated DON and the administrator were both out of the facility and all staff training was to be scheduled for 1/14/25. On 1/10/25 at 9:45 a.m., LPN-A stated when she entered R1's room on 1/7/24, R1 was "screaming out in pain", however, R1 does have a history of yelling out during cares. LPN-A stated it was obvious however, R1 was in 10/10 pain, and when asked what hurt R1 said his head hurt. On 1/10/25 at 9:52 a.m., NA-B and NA-C entered R1's room with the Hoyer lift due to R1 wanting to be transferred from his wheelchair into his bed. R1 had the Hoyer sling under him already, NA-B and NA-C both hooked the loops to the lift and NA-B then doubled checked all 4 loops. NA-B	2 830		

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2 830	Continued From page 8 operated the mechanical lift while NA-C guided R1 to the bed. NA-B lowered R1 onto the bed. On 1/10/25 at 10:18 a.m., NA-C stated she was a contracted agency staff and had been working at the facility for approximately three weeks. NA-C stated R1 required assist of two staff to transfer utilizing the Hoyer lift. NA-C stated she was aware R1 had a fall from the Hoyer lift however, was unsure of the details regarding the incident. NA-C stated for all Hoyer transfers, staff were expected to ensure all 4 loops were secured to the lift prior to transferring resident. Further, NA-C confirmed following R1's fall there has been no education provided to staff regarding mechanical lifts. On 1/10/25 at 11:40 a.m., attempted interview with DON was unsuccessful. Review of EZ Way Smart Lift Operator's Instructions revised 10/24/24, directed staff to make a final check of all four loop attachment points to ensure each loop was sufficiently attached to the respective hook of the hanger bars, and while lifting the patient continue upward motion until there was tension on the sling legs, make sure all the loops on the sling were securely hooked on the hanger bars. Review of facility policy titled EZ Way Smart Lifts revised 11/2/21, directed staff to check the condition of the sling before every use by checking entire sling for damage or wear including the loops and stitching, and if there were concerns with resident safety while transferring, stop the transfer, get assistance to keep the resident safe while getting the charge nurse. However, the policy did not direct staff to verify the loops were securely hooked prior to	2 830		

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	00474	A. BUILDING: _____ B. WING _____	C 01/10/2025

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
2 830	Continued From page 9 lifting the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or designee, should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		