Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 11, 2026

Administrator
GLENWOOD VILLAGE CARE CENTER
719 SOUTHEAST 2ND STREET
GLENWOOD, MN 56334

RE: CCN: 245402
Cycle Start Date: October 22, 2025

Dear Administrator:

On November 12, 2025, we notified you a remedy was imposed. On December 2, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 26, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 27, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 12, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 22, 2025. 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

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 11, 2026

Administrator
GLENWOOD VILLAGE CARE CENTER
719 SOUTHEAST 2ND STREET
GLENWOOD, MN 56334

Re: Reinspection Results
Event ID: 1D93C4-H2

Dear Administrator:

On December 2, 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 October 22, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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

*An equal opportunity employer.*

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

November 12, 2025

Administrator
GLENWOOD VILLAGE CARE CENTER
719 SOUTHEAST 2ND STREET
GLENWOOD, MN 56334

RE: CCN: 938342500

Cycle Start Date: October 22, 2025

Dear Administrator:

On October 22, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

**REMOVAL OF IMMEDIATE JEOPARDY**

On October 22, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of G.

**REMEDIES**

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 27, 2025.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 27, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 27, 2025, (42 CFR 488.417 (b)).

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.

**NURSE AIDE TRAINING PROHIBITION**

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 22, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

**SUBSTANDARD QUALITY OF CARE**

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's

administrator, be notified of the substandard quality of care.  If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care.  Therefore, GLENWOOD VILLAGE CARE CENTER is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 22, 2025.  This prohibition remains in effect for the specified period even though substantial compliance is attained.  Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met.  Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

**ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

**Susie Haben, Regional Operations Supervisor RR**
**Health Regulation Division**
**Minnesota Department of Health**
**4140 Thielman Lane**
**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, Licensing and Certification Program 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 April 22, 2026, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action

is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

**APPEAL RIGHTS DENIAL OF PAYMENT**

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

**tamika.brown@cms.hhs.gov**

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

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

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

## APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

## 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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 12, 2025

Administrator
GLENWOOD VILLAGE CARE CENTER
719 SOUTHEAST 2ND STREET
GLENWOOD, MN 56334

Re: State Nursing Home Licensing Orders
Event ID: 1D93C4-H1

Dear Administrator:

The above facility survey was completed on October 22, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

**Susie Haben, Regional Operations Supervisor RR**
**Health Regulation Division**
**Minnesota Department of Health**
**4140 Thielman Lane**
**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 feel free to call me with any 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**10/22/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GLENWOOD VILLAGE CARE CENTER** | **719 SOUTHEAST 2ND STREET , GLENWOOD, Minnesota, 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 |
|---|---|---|---|---|
| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 10/15/25 through 10/17/25 and 10/20/25 through 10/22/25, 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 identify the date when they will be completed. | 20000 | | |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**10/22/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GLENWOOD VILLAGE CARE CENTER** | **719 SOUTHEAST 2ND STREET , GLENWOOD, Minnesota, 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 |
|---|---|---|---|---|
| 20000 | Continued from page 1<br><br>The following complaints were reviewed:<br><br>H54025822C (2640987) and H54025827C (2643169/2644596) with a licensing order issued at 0830<br><br>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.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 20000 | | |
| 20830 | Adequate and Proper Nursing Care; General<br><br>CFR(s): MN Rule 4658.0520 Subp. 1<br><br>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 | 20830 | | 11/26/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**10/22/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **GLENWOOD VILLAGE CARE CENTER** | **719 SOUTHEAST 2ND STREET , GLENWOOD, Minnesota, 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 |
|---|---|---|---|---|
| 20830 | Continued from page 2<br>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.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to implement immediate interventions to prevent re-occurrence following a fall from a full body (EZ Way) mechanical lift for 1 of 1 residents reviewed (R4) who sustained two brain bleeds and a fracture. In addition, the facility failed to implement person centered fall interventions and complete a fall analysis for 1 of 3 residents reviewed (R1) who had multiple falls and fractures identified which resulted in actual harm.<br><br>On 10/16/25, R4 returned to the facility from a hospital stay related to her injuries that were sustained after she fell from the fully body mechanical lift during a transfer and upon returning from the hospital there were no immediate interventions implemented to prevent re-occurrence and was identified on 10/20/25.<br><br>Findings include:<br><br>R4’s quarterly Minimal Data Set (MDS) dated 8/27/25, indicated R4 had diagnoses which included hereditary and idiopathic neuropathy, polyneuropathy, chronic kidney disease stage 3, anxiety disorder, and morbid obesity.<br><br>R4’s care plan dated 3/16/25, indicated R4 had actual impaired functional status related to impaired gait and mobility, neuropathy, osteoarthritis, depression, opioid use, antipsychotic use and required staff assistance with transfers using Hoyer (full body mechanical lift) assistance of two staff members and a large sling. R4’s care plan was revised on 10/19/25, three days after R4 returned to the facility on 10/16/25, to include Hoyer sling to be removed from underneath resident after every transfer.<br><br>R4’s Fall-witnessed report dated 10/14/25 at 2:35 p.m., indicated writer was alerted to a resident fall that occurred in the resident’s room during a transfer from a lift. A small amount of blood was noted on the floor, as well as on the resident’s [R4] left ear and the left lower head just above the hairline. The resident was alert and oriented and verbalized “just get me off the | 20830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**10/22/2025** |
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| **GLENWOOD VILLAGE CARE CENTER** | **719 SOUTHEAST 2ND STREET , GLENWOOD, Minnesota, 56334** |

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| 20830 | Continued from page 3<br>floor". Range of motion was limited but within normal limits per her usual restrictions. The resident reported mild pain to the left posterior shoulder and right knee. The resident refused to have vital signs obtained prior to being assisted from the floor. A lift sheet was properly positioned, and the resident was assisted from the floor using a Hoyer lift with assistance from four staff members. Resident and staff were interviewed following the incident. The care plan was followed at the time of the fall, and the staffs transfer technique was observed immediately after the fall with no concerns noted. The resident was able to answer questions appropriately and participate in the assessment.<br><br>R4's progress notes revealed the following:<br><br>-On 10/14/25 at 2:35 p.m., R4 was being transferred with assist of two staff members and R4 fell from the lift.<br><br>-On 10/15/25, R4 was transferred to another hospital related to "bleeding in the brain".<br><br>-On 10/15/25, R4 was admitted to another hospital related to diagnosis of Traumatic subarachnoid and subdural hemorrhage. No tentative return date at this time.<br><br>-On 10/16/25, R4 returned to the facility at approximately 2:15 p.m., from the hospital. R4 was admitted for intracranial bleeding due to fall. Transfers with Hoyer lift and assist of two staff with a medium sling.<br><br>-On 10/19/25 at 12:43 p.m., a RN (registered nurse) Post Fall Follow-Up was completed. R4 continued to have pain in neck and right leg/knee. New intervention initiated was Hoyer sling to be removed from under resident after all transfers are completed and to be replaced behind resident for any further transfers. This would ensure sling is properly placed behind resident with every transfers. Root cause of resident's fall was determined to be the sling may not have been properly positioned behind resident while resident was being transferred resulting in resident not being secured.<br><br>On 10/19/25 at 3:52 p.m., R4 transferred to the emergency room (ER) due to possible DVT (deep vein thrombosis).<br><br>On 10/19/25 at 9:10 p.m., R4 returned to the facility | 20830 | | |

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| 20830 | Continued from page 4<br>by ambulance. R4 was diagnosed with peri-prosthetic distal transverse femur fracture. New orders to wear knee immobilizer whenever movement was occurring and Hydrocodone every 4-6 hours as needed for pain.<br><br>On 10/16/25 at 9:14 a.m., family member (FM)-A stated they were notified following the fall from the lift and R4 was brought to the ER and then transferred to another hospital due to two brain bleeds. FM-A stated R4 was unsure what happened or what caused the fall.<br><br>On 10/16/25 at 9:29 a.m., nursing assistant (NA)-A stated R4 required assist of two staff members and utilized a Hoyer lift for transfers. NA-A stated on 10/14/25 at approximately 2:30 p.m., R4 put on her call light and requested staff assistance with incontinence cares. NA-A stated she transferred R4 out of her electric wheelchair into R4's bed with assistance by NA-B, and there were no issues. NA-A stated staff then hooked R4 back up to the Hoyer lift and were going to transfer R4 from her bed back into her wheelchair, when R4 "fell out of her sling and onto the floor". Further, NA-A stated the loops on the sling remained attached to the lift, the legs of the sling were crossed, ensured the sling was covering R4's body appropriately shoulder and below tailbone, and the sling was intact. NA-A stated R4 was complaining of pain on her ear and her knee following the incident and R4 was sent to the ER. In addition, NA-A stated since the incident there has been no interventions implemented to prevent re-occurrence or changes to R4's care plan as well as no training or education provided to staff.<br><br>On 10/16/25 at 11:20 a.m., email was received from director of nursing (DON) stating she monitored all staff who were currently working during the transfer audits, answered questions, and provided education if needed. DON stated the facility would review the incident and educate all staff at the mandatory nursing department meeting that was scheduled for 10/29/25.<br><br>On 10/16/25 at 11:49 a.m., NA-B stated R4 was dependent on staff for all activities of daily living (ADLs) and required assist of two staff and a Hoyer lift for transfers. NA-B stated on 10/14/25 at approximately 2:45 p.m., NA-B was assisting NA-A transferring R4 from her bed back into her wheelchair after assisting R4 with incontinence cares. NA-B stated staff hooked R4's sling back onto the lift, lifted resident off the bed and pulled the lift away from the bed when R4 began to "giggle" and "went through the sling, her [R4] butt went through the opening of the legs which were crossed". NA-B stated R4's care plan identified R4 required the use of a size large sling for the Hoyer | 20830 | | |

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| 20830 | Continued from page 5<br>lift, but NA-B stated R4 should be switched to a size medium because the size large appeared to be too big. NA-B stated R4 “fell through” which resulted in R4 hitting her leg first on the ground then R4 hit her head on the Hoyer lift and R4 was sent to the ER. Further NA-B stated she reported to the DON following the incident NA-B’s concern regarding R4’s sling size and the large was too big for R4. In addition, NA-B stated there had been no changes to R4’s care plan since the incident and no education or training was completed following the incident.<br><br>On 10/16/25 at 12:51 p.m., NA-C stated R4 required assist of two staff for transfers utilizing a Hoyer lift and a large sling. NA-C stated R4’s size large sling is too big for R4. The top of the sling went over her head and the bottom of the sling was above the butt area or lower back. NA-C stated an appropriate size sling would included the top of the sling at the resident’s shoulder and the bottom of the sling would be around their butt. Further, NA-C stated she did not report the concerns of R4’s sling size to management but knew another staff had. NA-C stated she had heard R4 had laughed which made her fall through the sling. In addition, NA-C stated there had been no education, training or new interventions since the incident.<br><br>On 10/16/25 at 1:18 p.m., NA-D stated R4 required assist of two staff and a Hoyer lift for transfers. NA-D stated she heard R4 had fallen from the lift during a transfer and hit her head, and staff were stating R4’s sling did not fit her appropriately and the large sling was too big for her. NA-D stated R4 slid through the bottom of the sling and NA-D stated the actual cause of the fall was the improper use of the sling and staff did not have it underneath her the right way. Further, NA-D stated she had transferred R4 many times utilizing a large sling and NA-D did not have any concerns regarding the sling size and stated the large was appropriate and sometimes staff needed to readjust the sling under her to fit appropriately before transferring R4. In addition, NA-D stated a sling is an appropriate fit when the top of the sling was at the resident’s shoulders and the bottom of the sling was a little below the butt.<br><br>On 10/16/25 at 2:02 p.m., NA-E stated R4 required assist of two utilizing a Hoyer lift and size large sling for transfers. Further, NA-E stated a size large sling was appropriate for R4 and the medium was too small. NA-E state sling size was determined by the resident’s weight and the top of the sling should be at the resident’s shoulders and the bottom should be at the middle of their butt. | 20830 | | |

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| 20830 | Continued from page 6<br><br>On 10/16/25 at 3:12 p.m., NA-A stated she had no concerns with R4's sling size large and the sizing was appropriate as the top of the sling was at her shoulders and the bottom was at the middle of her butt.<br><br>On 10/16/25 at 3:42 p.m., registered nurse (RN)-A stated R4 required assist of two staff utilizing a Hoyer lift and a large sling for transfers. RN-A stated she had transferred R4 using the large sling and did not have concerns regarding sling size, and RN-A stated she was not aware of any staff concerns regarding R4's sling size. RN-A stated she heard R4 had fallen from the lift during a transfer and was sent to the hospital due to a brain bleed. RN-A stated R4 returned to the facility on this day (10/16/25) and staff were going to try to use a medium sling instead of a large sling for R4. Further, RN-A stated sling size was determined by reviewing the manufacturers guidelines for weight and R4's weight allows her to use a medium or a large sling according to the guidelines.<br><br>On 10/16/25 at 4:49 p.m., DON stated she was made aware of R4's incident immediately and began investigating what had happened. DON stated she inspected the sling R4 had been using at the time of the incident and the sling was the appropriate size and there were no defects noted. DON observed NA-A and NA-B assist R4 off the floor and back into her wheelchair and there were no concerns with the transfer. Further, DON stated she had determined the root cause of R4's fall from the lift was R4's clothing selection. DON stated R4 was wearing a night gown style clothing, a large baggy sweater over top, and due to R4's weight and material of the sling, this had caused R4 to fall through the lift. DON stated following the incident, audits were completed on all residents residing in the facility who utilized a Hoyer lift which included reviewing the care plans to ensure care plan matched appropriate sling size as well as observing staff transfer the resident. In addition, DON stated there was no other interventions implemented for R4's transfers and all staff education would be completed at the all-staff meeting.<br><br>On 10/16/25 at 5:09 p.m., EZ-Way (Hoyer lift company) sales representative (SR)-A stated they were made aware of R4's incident and reviewed R4's face sheet and determined a size large sling would have been an appropriate size for R4. Further, SR-A stated if nothing during the transfer malfunctioned and the sling remained intact and the loops attached during the transfer, the concern would have been the positioning of the sling under the resident and for the resident to | 20830 | | |

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| 20830 | Continued from page 7<br>fall through the sling with the leg straps crossed would have been the sling was positioned too high and above the tailbone, which would had resulted in the resident's bottom sticking through the bottom of the sling.<br><br>On 10/17/25 at 9:48 a.m., DON stated the nurse manager of each unit would be expected to assess each resident for appropriate sling size which would be based on the resident's weight. Further, DON stated an appropriate sling would be positioned at the top of the resident's shoulders and to the middle of their buttocks. In addition, DON stated staff do measure a resident for appropriate sling size, it was based off the resident's weight.<br><br>On 10/17/25 at 11:58 a.m., R4 was observed laying in her bed. DON used a soft tape measure and measured from R4's base of neck to two inches below her tailbone and stated it was 26 inches. DON stated staff had not switched R4 to a medium sling yet as indicated in R4's progress notes and R4 continued to utilize a size large. DON and NA-D attach the sling loops to the Hoyer lift and DON operated the machine while NA-D guided R4. R4 appeared to be positioned well in the sling as the top of the sling was at R4's shoulders and the bottom was below the tailbone.<br><br>On 10/21/25 at 1:52 p.m., R4 was in the hallway on her electric scooter and there was no sling under her.<br><br>On 10/21/25 at 1:58 p.m., trained medication aide (TMA)-A stated as of 10/19/25, staff were directed to remove R4's sling after transfers to ensure staff are double checking sling placement and the sling was intact.<br><br>On 10/21/25 at 2:00 p.m., licensed practical nurse (LPN)-A stated this was her first day on R4's unit since the incident and LPN-A was notified through report, staff were to remove the sling from under R4 following each transfer.<br><br>On 10/21/25 at 2:28 p.m., surveyor requested education provided to staff related to R4's care plan revision and new intervention as well as any other education that was completed.<br><br>On 10/21/25 at 3:20 p.m., R4 was in her room in her wheelchair and stated as of 10/20/25, staff now remove the sling from under her after each transfer.<br><br>On 10/21/25 at 3:23 p.m., NA-F stated she often will start her shift and check on R4 and noticed R4's sling | 20830 | | |

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| 20830 | Continued from page 8<br>is under her and the top part of the sling is above her head and not at her shoulders like it's supposed to be. NA-F stated she would report her concerns of sling positioning to the floor nurse but did not report to management.<br><br>On 10/21/25 at 4:53 p.m., surveyor again requested evidence of staff education related to R4's intervention and DON stated she was waiting on the nurse manager to give her the copies. Facility failed to provide a copy of education.<br><br>On 10/22/25 at 1:13 p.m., medical director (MD) stated he was made aware of R4's fall and R4 was sent to the ER and then admitted to the hospital related to a head injury. MD stated after R4 returned to the facility R4 continued to complain of pain in the lower right extremity and was sent to the ER where she was diagnosed with right distal fracture of the femur.<br><br>Review of Sling Sizing Chart provided by EZ Way, undated, indicated the size/weight designations were merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient. A proper fit would involve the judgement of the caregiver. Further, it was important that the base of the sling be positioned two inches below the tailbone and the top of the sling was parallel with the top of the shoulder line (base of neck).<br><br>Review of facility policy titled EZ Way Smart Lifts revised 1/14/25, directed staff to ensure all hooks are securely fastened before lifting resident, assist of two caregivers to assist with transfers for resident safety, and check the condition of the sling before every use by checking entire sling for damage or wear. When the lift was completed, disconnect the straps from the lift bar and remove sling by raising leg and pulling along the sides. However, facility policy lacked staff direction on proper sling placement prior to transfer and during transfer.<br><br>The immediate jeopardy that began on 10/16/25, was removed on 10/22/25, when the facility completed the following: audited R4's lift equipment to ensure the sling was the appropriate size and in good condition, DON observed a transfer with the staff and R4 to verify the resident was positioned safely and securely in the sling, R4's care plan was revised and directed staff to now remove the lift sheet immediately following each transfer, R4 would have a lift assessment conducted quarterly to ensure type of lift and sling remain appropriate, all staff educated on concerns regarding | 20830 | | |

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| 20830 | Continued from page 9<br>transfers and R4's intervention, and all staff have been re-educated per manufacturer's guidelines regarding proper sling application, loop selection, lift safety, and escalation procedures if concerns arrive, but the noncompliance remained at the lower scope and severity level 3.<br><br>R1's quarterly MDS dated 9/24/25, indicated R1's diagnoses included supraventricular tachycardia, abnormalities of gait and mobility, anxiety disorder and Alzheimer's disease. Further, MDS revealed R1 had one fall with no injury since previous assessment.<br><br>R1's care plan initiated 6/5/25, identified R1 was at high risk for falls related to diagnosis of anemia, impaired range of motion, anxiety, depression, poor communication/comprehension, dizziness with standing related to supraventricular tachycardia, unaware of safety needs, vision/hearing problems as exhibited by the need for a walker to stabilize, history of falls with major injury, difficulty with sitting balance and transitions, confusion, gait/balance problems and incontinence. R1's goal was to be free of falls through the review date and R1's interventions included: not to be left alone in dining room after meals, assist to toilet after meals and offer resident to join an activity, assist resident with p.m. cares and transfer to bed between 9-10 p.m., toileting schedule upon waking, before and after meals, and at hour of sleep and 2:00 a.m., staff assist of one with gait belt and 4-wheeled walker for all transfers/ambulation, assist R1 into her pajamas earlier in the evening to prevent her from doing this herself, call light within reach and encourage her to use it, appropriate non-slip footwear when ambulating, sign attached to walker reminding R1 to utilize, and medications as ordered for her diagnosis of supraventricular tachycardia. Further, R1's care plan identified R1 had exit seeking behaviors and will go from door-to-door looking to leave the facility and directed staff to redirect, offer an activity and reapproach with a different staff member.<br><br>R1's Fall Incident Report dated 9/26/25, indicated R1 was observed to have lost her footing with her right leg and fell sideways onto her left side of body but did not hit her head, witnessed by nurse and dietary aid. Approximately 30 minutes prior, R1 was assisted to the floor by the nurse when R1 lost her footing by the exit door, R1 was exit seeking. R1 was assessed and checked for injury, and none were noted at the time, and R1 did not allow staff to visually assess her and take vital signs as R1 was very angry. R1 was utilizing her walker at the time of the incident. Further, R1 was angry and wanted to go home so R1 walked fast with | 20830 | | |

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| 20830 | Continued from page 10<br>walker and her right foot seemed to give way when she was walking fast and was not paying attention because R1 was angry and would not redirect. Staff attempted to assist R1 to her recliner after the first incident and R1 refused any care offered. In addition, the incident report lacked evidence of a root cause analysis review completed by the interdisciplinary team (IDT) and lacked evidence of a new person-centered intervention to prevent future falls.<br><br>R1's Fall Incident Report dated 10/5/25, Resident was found sitting on floor with her legs extended and back was resting on side of her bed. R1 was unable to state what had happened and continued to state she wanted to go home. R1 was assessed for injury and non were noted at the time of the incident. R1 was assisted off the floor with a mechanical device and R1 had a pre-existing left arm fracture. R1's bed was noted to be in low position and R1 had transferred without assistance. Further, R1 tended to sundown and start exit seeking and R1 had been noted to be very confused that evening, refused meals, medications and care. In addition, the incident report lacked evidence of a root cause analysis review completed by the interdisciplinary team (IDT) and lacked evidence of a new person-centered intervention to prevent future falls.<br><br>R1's Progress Notes revealed the following:<br><br>-On 9/23/25, R1 complained of right side back pain near their ribs. No bruises or marks were observed in the area. R1 was offered pain medications and R1 declined.<br><br>-On 9/24/25, R1 was seen by her primary doctor and R1 denied having any questions or concerns.<br><br>-On 9/26/25, R1 has had an increase in reporting and signs of lower back/rib pain. R1 had been given as needed Tylenol more frequently as well due to right lower back/rib pain. Family requested that R1 have an x-ray completed. May we have orders for portable x-ray services to come to facility and do 2 views of the right side of the ribs and lower back, to rule out any possible fractures. Please advise.<br><br>-On 9/26/25, R1 had a fall in the hallway. R1 was very angry and agitated, the hall was calm, area clean. R1 had landed on her left side and did not hit her head. No apparent injuries were noted and R1 denied pain. R1 had a near fall 30 minutes prior to this fall and the nurse had to lower R1 to the floor. R1 walks very fast when she was angry and her right left noted to give way and fell to the left. R1 would not allow for nurse to | 20830 | | |

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| 20830 | Continued from page 11<br>observe her skin or obtain vital signs. R1 was assisted to sit in her recliner then later assisted to recliner in commons area to keep resident within view.<br><br>-On 9/27/25, portable x-ray services called to come to facility and x-ray R1's lumbar spine and right ribs.<br><br>-On 9/29/25, family meeting R1 at the clinic for an appointment<br><br>-On 9/29/25, call placed to radiology department, no results yet from imaging performed to resident's arm today.<br><br>-On 9/30/25, family called to report she had set up an appointment for 9/30/25 for a follow up orthopedics appointment related to R1's x-ray results.<br><br>-On 9/30/25, R1 had x-ray done to the left elbow and shoulder. Results will be faxed over from radiology.<br><br>-On 10/1/25, spoke with clinic and orthopedic specialist and appointment scheduled to apply splint to left arm.<br><br>-On 10/2/25, physician visit note revealed assessed pain in left upper extremity, noted left elbow skin tear and left elbow radial head fracture.<br><br>-On 10/3/25, R1 complained of hurting all over and an ice pack was applied to left arm.<br><br>-On 10/4/25, R1 was agitated and wanting to go home, complained of pain. R1 observed by staff member attempt to stand without assistance, because she wanted to go home, R1 was assisted to wheelchair due to weakness and previous fall with fracture to left arm.<br><br>-On 10/5/25, R1had a fall in resident's room. R1 was observed to be sitting on the floor next to her bed and her back was resting on the bed. R1 had an existing left arm fracture, and no other injury was noted. R1 had been agitated all evening wanting to go home. R1's bed was in lowest position, frequent checks were performed, and one to one staff was implemented.<br><br>-On 10/5/25, R1 was transferred to the ER and admitted to the hospital.<br><br>R1's progress notes lacked evidence of IDT root cause analysis following two falls on 9/26/25 and the one fall on 10/5/25. In addition, there also was not evidence of new interventions implemented to prevent future falls and injuries. | 20830 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| 20830 | Continued from page 12<br><br>R1's Patient Report, from portable x-ray company, dated 9/28/25, indicated R1 had pain after fall and findings included right lateral 8th and 9th rib fractures.<br><br>R1's Office Visit note dated 10/2/25, indicated R1 had multiple falls recently last week. R1 had an x-ray of her left elbow that showed a radial head fracture, which was nondisplaced. R1 was referred to our office for definitive management of the fracture. The patient right now states there was no pain over the elbow and denied range of motion deficits of that elbow. However, there was a skin tear of the left elbow.<br><br>On 10/15/25 at 1:06 p.m., family member (FM)-A stated R1 would have frequent falls and R1 would not always report her falls to the staff at the facility. FM-A stated she was not aware of interventions the facility staff were attempting to prevent falls other than there was a sign on R1's walker. Further, FM-A stated R1 had three falls in a short period of time and R1 did sustain fractures of the ribs and elbow from the falls.<br><br>On 10/15/25 at 2:51 p.m., LPN-B stated R1 had impaired cognition and would often become agitated and attempt to leave and exit seek in the evenings. When R1 would exhibit these behaviors, LPN-B stated R1 would often lose her gait and had falls. LPN-B stated R1 was at risk for falls and R1 had reported falls to her granddaughter that R1 had not reported to staff before. LPN-B stated she was working when R1 had the two falls on 9/26/25, and following the falls LPN-B stated staff were "watching her closely" as an intervention but was not aware of any care plan changes for long term interventions following those two falls. Further, LPN-B stated she was also working on the 10/5/25 fall and R1 did not complain of pain at the time but had a pre existing left arm fracture, and staff were completing frequent checks through out the night and again LPN-B could not recall any new interventions implemented following that fall as R1 was admitted to the hospital and returned to the facility on Hospice services.<br><br>On 10/15/25 at 3:21 p.m., NA-A stated R1 was at risk for falls and NA-A stated "I don't think we really had many to be honest" when asked what interventions staff would implement to prevent R1 from falling. NA-A stated R1's door to her room would be kept open and staff would check on her and assist with cares as needed. NA-A stated she was working the overnight on 10/5/25, and at approximately 1:00 a.m. NA-A found R1 on the floor and R1 was last seen at 11:30 p.m. sleeping in her bed. | 20830 | | |

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| 20830 | Continued from page 13<br><br>On 10/16/25 at 11:49 a.m., NA-B stated R1 exhibited behaviors of wandering and attempted to escape out of the doors. NA-B stated R1 was identified as a fall risk and stated, “she didn’t have many interventions for falls”, and staff were directed to keep R1 close to the nursing station, bring her to activities, and R1 had a toileting schedule. Further, NA-B stated fall interventions were in the resident’s care plan for staff to reference.<br><br>On 10/16/25 at 12:51 p.m., NA-C stated R1 appeared to be more confused in the afternoon into the evenings and R1 often would express wanting to go home. NA-C stated staff would attempt to redirect her, offer activities, assist with walking, or provide a one-to-one staff to de-escalate behaviors. NA-C stated R1 was at risk for falls and staff were directed to leave walker within reach, keep room door open, and had a toileting program. Further, NA-C stated R1 has sustained rib fractures and an arm fracture from recent falls.<br><br>On10/16/25 at 3:42 p.m., RN-A stated R1 appeared to be confused and would attempt to exit seek and self-transfer. RN-A stated R1 was at risk for falls and interventions included assist R1 with nighttime care, transfer to her bed between 9-10 p.m., toileting schedule, walker with a sign attached, appropriate footwear while ambulating and keep her call light within reach even though she would not utilize her call light. RN-A stated R1 had two falls that occurred on 9/26/25, the first fall was due to weakness and the second fall was R1 lost her footing. RN-A stated she reviewed both falls and the long-term intervention was to have R1 out in the recliner in the commons area within view, however RN-A could not give further detail on when staff would be directed to implement this intervention, and the intervention was not communicated to staff and R1’s care plan was not revised. Further, RN-A stated the root cause for R1’s fall on 10/5/25 was R1 was agitated all evening and refusing care, and RN-A stated there was no long-term intervention implemented due to R1 being transferred to the hospital and returning to the facility on hospice. In addition, RN-A stated facility process for falls included RN-A reviewing each fall and determining a root cause, and reviewing the immediate intervention staff implemented for appropriateness and adjusting intervention if not appropriate. RN-A confirmed a RN follow up note which would include the root cause analysis of the fall, IDT input, and a new intervention was not completed for R1’s three falls per facility protocol.<br><br>On 10/16/25 at 4:49 p.m., DON stated R1 had a fall at | 20830 | | |

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| 20830 | Continued from page 14<br>the end of September in the hallway and R1 did not have any injuries at the time. DON stated R1 had self-reported a fall to staff and she was having pain, however there were no reports of R1 having a fall and DON was questioning if R1 had fallen into something. R1 obtained x-rays which revealed rib fractures and an elbow fracture. DON stated R1 had another fall from her bed and was sent to the hospital and returned on palliative care. Further, DON stated the nurse manager on the unit would be responsible for reviewing each fall and completing a follow up note with an intervention. DON stated the floor staff would be expected to implement an immediate intervention until the nurse manager reviewed the fall and determines an appropriate intervention and then updates the resident's care plan and communicates revisions in the nurses' report.<br><br>On 10/16/25 at 5:29 p.m., surveyor receive email from DON which revealed: After reviewing the fall that occurred on 9/26, it was noted that the nurse on duty implemented an intervention to keep the resident within view in the common area. However, upon further review with the nurse manager responsible for the resident at the time, it was identified that an RN fall follow-up was not completed. We will be proceeding with progressive counseling for the RN regarding this incident and will provide education to all staff on appropriate fall interventions during our next team meeting on 10/29.<br><br>On 10/17/25 at 9:48 a.m., DON stated prior to R1's fall on 9/26/25, R1 had been reporting she fell but there was no bruising noted to the area. On 9/26/25, there was a progress note regarding increased rib pain. DON stated she was made aware of R1's rib fractures on 9/29/25, and DON stated she was assuming R1 had fallen against something because there was no evidence of other falls. DON stated she interviewed a couple of the nurses who were not aware of any additional falls, and DON stated she should have investigated the fractures more following that. Further, DON confirmed R1's two falls on 9/26/25, did not have evidence of a RN follow-up note or new interventions implemented to prevent future falls. DON stated R1 had an x-ray of her arm following the fall on 9/26/25, and DON reviewed the radiology report and interpreted as not being a definite fracture but more than likely the fracture would have been associated with R1's fall. DON confirmed R1's fall that occurred on 10/5/25, did not have an RN follow-up completed either with a root cause analysis or new intervention. | 20830 | | |

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| 20830 | Continued from page 15<br><br>On 10/16/25 at 11;06 a.m., LPN-C stated R1 would exhibit sundowning behaviors and want to leave the facility and R1 would be challenging to redirect. LPN-C recalls R1 reporting she had fallen but there was no documentation by staff of any other falls because no staff had found her, R1 just kept reporting she fell.<br><br>On 10/16/25 at 11:19 a.m., NA-G stated R1 had impaired cognition and was at risk for falls. NA-G stated staff were assuming R1 was falling and not reporting the falls to staff. NA-G stated she had heard noises coming from R1's room but upon arrival R1 was not on the floor and R1 would deny a fall.<br><br>On 10/21/25 at 10:42 a.m., attempted interview with R1's physician unsuccessful.<br><br>Review of facility policy titled Fall Prevention and Management revised 6/11/25, defined an intercepted fall as when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person, this would still be considered a fall. Further, policy revealed clinical manager was responsible for implementation and oversight of individualized residents fall prevention care as follows: collaborating with the IDT in the prevention of falls, appropriately managing resident who experience a fall by implementing interventions to prevent further falls, and care plan would be updated to reflect individual needs for safety. The new intervention would be monitored for effectiveness every shift for 48 hours after implementation notation of effectiveness should occur in the medical record.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analysis of falls occurs for fall prevention. The DON or designee should educate staff and conduct measurable audits of fall to ensure analysis of the root cause is completed, and ensure identified interventions are in place to prevent falls. The DON or designee should ensure the results of those audits are taken to QAPI to determine compliance or the need for ongoing monitoring.<br><br>TIMEFRAME FOR CORRECTION: Twenty-One (21) days. | 20830 | | |

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| F0000 | INITIAL COMMENTS<br><br>On 10/15/25 through 10/17/25 and 10/20/25 through 10/22/25, 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.<br><br>H54025822C (2640987) and H54025827C (2643169/2644596) with a deficiency issued at F689.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to implement immediate interventions to prevent re-occurrence following a fall from a full body (Hoyer) mechanical lift for 1 of 3 residents reviewed (R4) who sustained two brain bleeds and a fracture. The IJ began on 10/14/25, and the immediacy was removed on 10/22/25.<br><br>The above findings constituted substandard quality of care, and an extended survey was conducted on 10/22/25.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F0000 | | |
| F0689<br>SS = SQC-J | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that - | F0689 | Plan of Correction - F689<br><br>Address how the facility will correct the deficiency as it relates to the individual.<br><br>Following the incident with R4, the Director of Nursing | 11/26/2025 |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0689 SS = SQC-J | Continued from page 1<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to implement immediate interventions to prevent re-occurrence following a fall from a full body (EZ Way) mechanical lift for 1 of 1 residents reviewed (R4) who sustained two brain bleeds and a fracture. This resulted in an immediate jeopardy (IJ). In addition to the resident in immediate jeopardy, the facility failed to implement person centered fall interventions and complete a fall analysis for 1 of 3 residents reviewed (R1) who had multiple falls and fractures identified which resulted in actual harm.<br><br>The immediate jeopardy began on 10/16/25, when R4 returned to the facility from a hospital stay related to her injuries that were sustained after she fell from the fully body mechanical lift during a transfer and upon returning from the hospital there were no immediate interventions implemented to prevent re-occurrence, and was identified on 10/20/25. The administrator, director of nursing (DON), and assistant director of nursing (ADON) were notified of the immediate jeopardy at 6:15 p.m. on 10/20/25. The immediate jeopardy was removed on 10/22/25, but noncompliance remained at the lower scope and severity level 3, G scope and severity level, which indicated actual harm that is not immediate jeopardy.<br><br>Findings include:<br><br>R4's quarterly Minimal Data Set (MDS) dated 8/27/25, indicated R4 had diagnoses which included hereditary and idiopathic neuropathy, polyneuropathy, chronic kidney disease stage 3, anxiety disorder, and morbid obesity.<br><br>R4's care plan dated 3/16/25, indicated R4 had actual impaired functional status related to impaired gait and mobility, neuropathy, osteoarthritis, depression, opioid use, antipsychotic use and required staff assistance with transfers using Hoyer (full body mechanical lift) assistance of two staff members and a large sling. R4's care plan was revised on 10/19/25, three days after R4 returned to the facility on | F0689 | Continued from page 1<br>(DON) immediately audited the resident's lift equipment to ensure the sling was the appropriate size and in good working condition, with no rips, tears, or signs of distress noted. The DON also directly observed a subsequent transfer with the staff involved in the incident to verify that the resident was positioned safely and securely in the sling throughout the lift.<br><br>Upon investigation, it was identified that the resident's care plan directed staff to leave the Hoyer lift sheet under the resident while in bed and in the wheelchair. To enhance safety and prevent recurrence, the care plan was revised to include a new intervention requiring staff to remove the lift sheet immediately following transfers.<br><br>The resident has declined removal of the sling while seated in the wheelchair, citing increased pain and discomfort during removal and replacement. The risk versus benefit was discussed with the resident, who expressed understanding and continued to prefer keeping the sling under them while in the chair.<br><br>This revision ensures that staff reapply the lift sheet prior to transferring out of the bed, allowing for proper placement, and verification of fit. Staff will receive verbal education and be required to review the updated Care Plan, Kardex, and related policy, and sign an acknowledgment form to confirm understanding.<br><br>R4 will have a lift assessment conducted by a Registered Nurse at least quarterly and with any significant change in condition to ensure the type of lift and sling remain appropriate for the resident's current needs. All staff have been and will continue to be educated to promptly notify the RN, DON, or ADON if any concerns arise regarding resident transfers or lift equipment.<br><br>R1 is no longer a resident of the facility; therefore, no updates can be made to their plan of care. The identified learning opportunities will be addressed through staff education. Staff will receive verbal education and will be required to review the Fall Prevention and Management Policy and sign an acknowledgment form to confirm understanding.<br><br>How the Facility Will Act to Protect Residents in Similar Situations:<br><br>All residents who require HOYER lift transfers had immediate audits completed to verify the sling in use | |

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| F0689 SS = SQC-J | Continued from page 2<br>10/16/25, to include Hoyer sling to be removed from underneath resident after every transfer.<br><br>R4's Fall-witnessed report dated 10/14/25 at 2:35 p.m., indicated writer was alerted to a resident fall that occurred in the resident's room during a transfer from a lift. A small amount of blood was noted on the floor, as well as on the resident's [R4] left ear and the left lower head just above the hairline. The resident was alert and oriented and verbalized "just get me off the floor". Range of motion was limited but within normal limits per her usual restrictions. The resident reported mild pain to the left posterior shoulder and right knee. The resident refused to have vital signs obtained prior to being assisted from the floor. A lift sheet was properly positioned, and the resident was assisted from the floor using a Hoyer lift with assistance from four staff members. Resident and staff were interviewed following the incident. The care plan was followed at the time of the fall, and the staffs transfer technique was observed immediately after the fall with no concerns noted. The resident was able to answer questions appropriately and participate in the assessment.<br><br>R4's progress notes revealed the following:<br><br>-On 10/14/25 at 2:35 p.m., R4 was being transferred with assist of two staff members and R4 fell from the lift.<br><br>-On 10/15/25, R4 was transferred to another hospital related to "bleeding in the brain".<br><br>-On 10/15/25, R4 was admitted to another hospital related to diagnosis of Traumatic subarachnoid and subdural hemorrhage. No tentative return date at this time.<br><br>-On 10/16/25, R4 returned to the facility at approximately 2:15 p.m., from the hospital. R4 was admitted for intracranial bleeding due to fall. Transfers with Hoyer lift and assist of two staff with a medium sling.<br><br>-On 10/19/25 at 12:43 p.m., a RN (registered nurse) Post Fall Follow-Up was completed. R4 continued to have pain in neck and right leg/knee. New intervention initiated was Hoyer sling to be removed from under resident after all transfers are completed and to be replaced behind resident for any further transfers. This would ensure sling is properly placed behind resident with every transfers. Root cause of resident's | F0689 | Continued from page 2<br>was the appropriate size based on resident weight and manufacturer's guidelines, and that each sling was in good working condition. Resident care plans were reviewed and updated as needed to ensure the correct sling size and transfer method were clearly documented.<br><br>The Assistant Director of Nursing (ADON) and DON completed a "Lift Transfer Assessment" for each resident in the facility who utilizes a HOYER. This assessment includes, but is not limited to, verifying proper sling size based on height and weight, assessing trunk control, and ensuring alignment with manufacturer recommendations.<br><br>Following the initial facility-wide assessment, RN Case Managers will conduct lift assessments upon admission, quarterly, annually, and with any significant change in condition for residents who require mechanical lift transfers. All completed assessments and care plan updates will be documented in the resident's medical record and tracked for completion by the DON.<br><br>All staff responsible for lift transfers have been re-educated per manufacturer's guidelines, and will continue to receive ongoing education, regarding proper sling application, loop selection, lift safety, and escalation procedures if concerns arise. Competency will be verified through direct observation and documentation.<br><br>Staff responsible for completion of the "RN Post-Fall Follow-Up" received education reinforcing the expectation that they ensure timely, person-centered interventions are implemented to prevent further falls, documentation is completed accurately, and all required education is provided.<br><br>Address what measures will be put into place or systemic changes made to ensure that the problem does not recur.<br><br>Staff education on the identified deficient practice was completed prior to their next working shift following the incident with R4. The incident was reviewed at the next Nursing Department meeting on 10/29, during all-staff meetings on 11/12 and 11/13, and again at the following Nursing Department meeting on 11/26.<br><br>The facility's EZ Way Lift Policy has been updated to include a section addressing factors that may impact sling loop determination during each transfer. All | |

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| F0689 SS = SQC-J | Continued from page 3<br>fall was determined to be the sling may not have been properly positioned behind resident while resident was being transferred resulting in resident not being secured.<br><br>On 10/19/25 at 3:52 p.m., R4 transferred to the emergency room (ER) due to possible DVT (deep vein thrombosis).<br><br>On 10/19/25 at 9:10 p.m., R4 returned to the facility by ambulance. R4 was diagnosed with peri-prosthetic distal transverse femur fracture. New orders to wear knee immobilizer whenever movement was occurring and Hydrocodone every 4-6 hours as needed for pain.<br><br>On 10/16/25 at 9:14 a.m., family member (FM)-A stated they were notified following the fall from the lift and R4 was brought to the ER and then transferred to another hospital due to two brain bleeds. FM-A stated R4 was unsure what happened or what caused the fall.<br><br>On 10/16/25 at 9:29 a.m., nursing assistant (NA)-A stated R4 required assist of two staff members and utilized a Hoyer lift for transfers. NA-A stated on 10/14/25 at approximately 2:30 p.m., R4 put on her call light and requested staff assistance with incontinence cares. NA-A stated she transferred R4 out of her electric wheelchair into R4's bed with assistance by NA-B, and there were no issues. NA-A stated staff then hooked R4 back up to the Hoyer lift and were going to transfer R4 from her bed back into her wheelchair, when R4 "fell out of her sling and onto the floor". Further, NA-A stated the loops on the sling remained attached to the lift, the legs of the sling were crossed, ensured the sling was covering R4's body appropriately shoulder and below tailbone, and the sling was intact. NA-A stated R4 was complaining of pain on her ear and her knee following the incident and R4 was sent to the ER. In addition, NA-A stated since the incident there has been no interventions implemented to prevent re-occurrence or changes to R4's care plan as well as no training or education provided to staff.<br><br>On 10/16/25 at 11:20 a.m., email was received from director of nursing (DON) stating she monitored all staff who were currently working during the transfer audits, answered questions, and provided education if needed. DON stated the facility would review the incident and educate all staff at the mandatory nursing department meeting that was scheduled for 10/29/25.<br><br>On 10/16/25 at 11:49 a.m., NA-B stated R4 was dependent on staff for all activities of daily living (ADLs) and required assist of two staff and a Hoyer lift for | F0689 | Continued from page 3<br>staff have been educated on the updated policy, including proper sling selection, loop placement, and verification of fit, ensuring resident safety prior to each lift.<br><br>Competency of all staff using mechanical lifts will be assessed through direct observation by the DON or designee. Any staff identified as needing additional training will receive immediate re-education.<br><br>The facility's Fall Prevention & Management Policy has been updated to reflect expectations regarding the timely completion of interventions and appropriate follow-up by the RN responsible for the resident.<br><br>Indicate how the facility will monitor its performance to make sure that solutions are sustained.<br><br>To ensure sustained compliance, audits of lift transfers, post-fall follow-up documentation, and care plan adherence will be conducted weekly for four weeks, then monthly for three months, then randomly after that. Findings from these audits will be reported to the QA Committee. These measures are intended to protect all residents and reduce the risk of recurrence of lift-related incidents, as well as recurring falls due to missed or incomplete interventions.<br><br>The plan of correction must provide dates when corrective action will be completed.<br><br>11/26/2025 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F0689 SS = SQC-J | Continued from page 4<br>transfers. NA-B stated on 10/14/25 at approximately 2:45 p.m., NA-B was assisting NA-A transferring R4 from her bed back into her wheelchair after assisting R4 with incontinence cares. NA-B stated staff hooked R4's sling back onto the lift, lifted resident off the bed and pulled the lift away from the bed when R4 began to "giggle" and "went through the sling, her [R4] butt went through the opening of the legs which were crossed". NA-B stated R4's care plan identified R4 required the use of a size large sling for the Hoyer lift, but NA-B stated R4 should be switched to a size medium because the size large appeared to be too big. NA-B stated R4 "fell through" which resulted in R4 hitting her leg first on the ground then R4 hit her head on the Hoyer lift and R4 was sent to the ER. Further NA-B stated she reported to the DON following the incident NA-B's concern regarding R4's sling size and the large was too big for R4. In addition, NA-B stated there had been no changes to R4's care plan since the incident and no education or training was completed following the incident.<br><br>On 10/16/25 at 12:51 p.m., NA-C stated R4 required assist of two staff for transfers utilizing a Hoyer lift and a large sling. NA-C stated R4's size large sling is too big for R4. The top of the sling went over her head and the bottom of the sling was above the butt area or lower back. NA-C stated an appropriate size sling would included the top of the sling at the resident's shoulder and the bottom of the sling would be around their butt. Further, NA-C stated she did not report the concerns of R4's sling size to management but knew another staff had. NA-C stated she had heard R4 had laughed which made her fall through the sling. In addition, NA-C stated there had been no education, training or new interventions since the incident.<br><br>On 10/16/25 at 1:18 p.m., NA-D stated R4 required assist of two staff and a Hoyer lift for transfers. NA-D stated she heard R4 had fallen from the lift during a transfer and hit her head, and staff were stating R4's sling did not fit her appropriately and the large sling was too big for her. NA-D stated R4 slid through the bottom of the sling and NA-D stated the actual cause of the fall was the improper use of the sling and staff did not have it underneath her the right way. Further, NA-D stated she had transferred R4 many times utilizing a large sling and NA-D did not have any concerns regarding the sling size and stated the large was appropriate and sometimes staff needed to readjust the sling under her to fit appropriately before transferring R4. In addition, NA-D stated a sling is an appropriate fit when the top of the sling was at the resident's shoulders and the bottom of the | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245402 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/22/2025 |
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| F0689 SS = SQC-J | Continued from page 5<br>sling was a little below the butt.<br><br>On 10/16/25 at 2:02 p.m., NA-E stated R4 required assist of two utilizing a Hoyer lift and size large sling for transfers. Further, NA-E stated a size large sling was appropriate for R4 and the medium was too small. NA-E state sling size was determined by the resident's weight and the top of the sling should be at the resident's shoulders and the bottom should be at the middle of their butt.<br><br>On 10/16/25 at 3:12 p.m., NA-A stated she had no concerns with R4's sling size large and the sizing was appropriate as the top of the sling was at her shoulders and the bottom was at the middle of her butt.<br><br>On 10/16/25 at 3:42 p.m., registered nurse (RN)-A stated R4 required assist of two staff utilizing a Hoyer lift and a large sling for transfers. RN-A stated she had transferred R4 using the large sling and did not have concerns regarding sling size, and RN-A stated she was not aware of any staff concerns regarding R4's sling size. RN-A stated she heard R4 had fallen from the lift during a transfer and was sent to the hospital due to a brain bleed. RN-A stated R4 returned to the facility on this day (10/16/25) and staff were going to try to use a medium sling instead of a large sling for R4. Further, RN-A stated sling size was determined by reviewing the manufacturers guidelines for weight and R4's weight allows her to use a medium or a large sling according to the guidelines.<br><br>On 10/16/25 at 4:49 p.m., DON stated she was made aware of R4's incident immediately and began investigating what had happened. DON stated she inspected the sling R4 had been using at the time of the incident and the sling was the appropriate size and there were no defects noted. DON observed NA-A and NA-B assist R4 off the floor and back into her wheelchair and there were no concerns with the transfer. Further, DON stated she had determined the root cause of R4's fall from the lift was R4's clothing selection. DON stated R4 was wearing a night gown style clothing, a large baggy sweater over top, and due to R4's weight and material of the sling, this had caused R4 to fall through the lift. DON stated following the incident, audits were completed on all residents residing in the facility who utilized a Hoyer lift which included reviewing the care plans to ensure care plan matched appropriate sling size as well as observing staff transfer the resident. In addition, DON stated there was no other interventions implemented for R4's transfers and all staff education would be completed at the all-staff meeting. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 6<br><br>On 10/16/25 at 5:09 p.m., EZ-Way (Hoyer lift company) sales representative (SR)-A stated they were made aware of R4's incident and reviewed R4's face sheet and determined a size large sling would have been an appropriate size for R4. Further, SR-A stated if nothing during the transfer malfunctioned and the sling remained intact and the loops attached during the transfer, the concern would have been the positioning of the sling under the resident and for the resident to fall through the sling with the leg straps crossed would have been the sling was positioned too high and above the tailbone, which would had resulted in the resident's bottom sticking through the bottom of the sling.<br><br>On 10/17/25 at 9:48 a.m., DON stated the nurse manager of each unit would be expected to assess each resident for appropriate sling size which would be based on the resident's weight. Further, DON stated an appropriate sling would be positioned at the top of the resident's shoulders and to the middle of their buttocks. In addition, DON stated staff do measure a resident for appropriate sling size, it was based off the resident's weight.<br><br>On 10/17/25 at 11:58 a.m., R4 was observed laying in her bed. DON used a soft tape measure and measured from R4's base of neck to two inches below her tailbone and stated it was 26 inches. DON stated staff had not switched R4 to a medium sling yet as indicated in R4's progress notes and R4 continued to utilize a size large. DON and NA-D attach the sling loops to the Hoyer lift and DON operated the machine while NA-D guided R4. R4 appeared to be positioned well in the sling as the top of the sling was at R4's shoulders and the bottom was below the tailbone.<br><br>On 10/21/25 at 1:52 p.m., R4 was in the hallway on her electric scooter and there was no sling under her.<br><br>On 10/21/25 at 1:58 p.m., trained medication aide (TMA)-A stated as of 10/19/25, staff were directed to remove R4's sling after transfers to ensure staff are double checking sling placement and the sling was intact.<br><br>On 10/21/25 at 2:00 p.m., licensed practical nurse (LPN)-A stated this was her first day on R4's unit since the incident and LPN-A was notified through report, staff were to remove the sling from under R4 following each transfer.<br><br>On 10/21/25 at 2:28 p.m., surveyor requested education | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 7<br>provided to staff related to R4's care plan revision and new intervention as well as any other education that was completed.<br><br>On 10/21/25 at 3:20 p.m., R4 was in her room in her wheelchair and stated as of 10/20/25, staff now remove the sling from under her after each transfer.<br><br>On 10/21/25 at 3:23 p.m., NA-F stated she often will start her shift and check on R4 and noticed R4's sling is under her and the top part of the sling is above her head and not at her shoulders like it's supposed to be. NA-F stated she would report her concerns of sling positioning to the floor nurse but did not report to management.<br><br>On 10/21/25 at 4:53 p.m., surveyor again requested evidence of staff education related to R4's intervention and DON stated she was waiting on the nurse manager to give her the copies. Facility failed to provide a copy of education.<br><br>On 10/22/25 at 1:13 p.m., medical director (MD) stated he was made aware of R4's fall and R4 was sent to the ER and then admitted to the hospital related to a head injury. MD stated after R4 returned to the facility R4 continued to complain of pain in the lower right extremity and was sent to the ER where she was diagnosed with right distal fracture of the femur.<br><br>Review of Sling Sizing Chart provided by EZ Way, undated, indicated the size/weight designations were merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient. A proper fit would involve the judgement of the caregiver. Further, it was important that the base of the sling be positioned two inches below the tailbone and the top of the sling was parallel with the top of the shoulder line (base of neck).<br><br>Review of facility policy titled EZ Way Smart Lifts revised 1/14/25, directed staff to ensure all hooks are securely fastened before lifting resident, assist of two caregivers to assist with transfers for resident safety, and check the condition of the sling before every use by checking entire sling for damage or wear. When the lift was completed, disconnect the straps from the lift bar and remove sling by raising leg and pulling along the sides. However, facility policy lacked staff direction on proper sling placement prior to transfer and during transfer.<br><br>The immediate jeopardy that began on 10/16/25, was | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 8<br>removed on 10/22/25, when the facility completed the following: audited R4's lift equipment to ensure the sling was the appropriate size and in good condition, DON observed a transfer with the staff and R4 to verify the resident was positioned safely and securely in the sling, R4's care plan was revised and directed staff to now remove the lift sheet immediately following each transfer, R4 would have a lift assessment conducted quarterly to ensure type of lift and sling remain appropriate, all staff educated on concerns regarding transfers and R4's intervention, and all staff have been re-educated per manufacturer's guidelines regarding proper sling application, loop selection, lift safety, and escalation procedures if concerns arrive, but the noncompliance remained at the lower scope and severity level 3.<br><br>R1's quarterly MDS dated 9/24/25, indicated R1's diagnoses included supraventricular tachycardia, abnormalities of gait and mobility, anxiety disorder and Alzheimer's disease. Further, MDS revealed R1 had one fall with no injury since previous assessment.<br><br>R1's care plan initiated 6/5/25, identified R1 was at high risk for falls related to diagnosis of anemia, impaired range of motion, anxiety, depression, poor communication/comprehension, dizziness with standing related to supraventricular tachycardia, unaware of safety needs, vision/hearing problems as exhibited by the need for a walker to stabilize, history of falls with major injury, difficulty with sitting balance and transitions, confusion, gait/balance problems and incontinence. R1's goal was to be free of falls through the review date and R1's interventions included: not to be left alone in dining room after meals, assist to toilet after meals and offer resident to join an activity, assist resident with p.m. cares and transfer to bed between 9-10 p.m., toileting schedule upon waking, before and after meals, and at hour of sleep and 2:00 a.m., staff assist of one with gait belt and 4-wheeled walker for all transfers/ambulation, assist R1 into her pajamas earlier in the evening to prevent her from doing this herself, call light within reach and encourage her to use it, appropriate non-slip footwear when ambulating, sign attached to walker reminding R1 to utilize, and medications as ordered for her diagnosis of supraventricular tachycardia. Further, R1's care plan identified R1 had exit seeking behaviors and will go from door-to-door looking to leave the facility and directed staff to redirect, offer an activity and reapproach with a different staff member.<br><br>R1's Fall Incident Report dated 9/26/25, indicated R1 was observed to have lost her footing with her right | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 9<br>leg and fell sideways onto her left side of body but did not hit her head, witnessed by nurse and dietary aid. Approximately 30 minutes prior, R1 was assisted to the floor by the nurse when R1 lost her footing by the exit door, R1 was exit seeking. R1 was assessed and checked for injury, and none were noted at the time, and R1 did not allow staff to visually assess her and take vital signs as R1 was very angry. R1 was utilizing her walker at the time of the incident. Further, R1 was angry and wanted to go home so R1 walked fast with walker and her right foot seemed to give way when she was walking fast and was not paying attention because R1 was angry and would not redirect. Staff attempted to assist R1 to her recliner after the first incident and R1 refused any care offered. In addition, the incident report lacked evidence of a root cause analysis review completed by the interdisciplinary team (IDT) and lacked evidence of a new person-centered intervention to prevent future falls.<br><br>R1's Fall Incident Report dated 10/5/25, Resident was found sitting on floor with her legs extended and back was resting on side of her bed. R1 was unable to state what had happened and continued to state she wanted to go home. R1 was assessed for injury and non were noted at the time of the incident. R1 was assisted off the floor with a mechanical device and R1 had a pre-existing left arm fracture. R1's bed was noted to be in low position and R1 had transferred without assistance. Further, R1 tended to sundown and start exit seeking and R1 had been noted to be very confused that evening, refused meals, medications and care. In addition, the incident report lacked evidence of a root cause analysis review completed by the interdisciplinary team (IDT) and lacked evidence of a new person-centered intervention to prevent future falls.<br><br>R1's Progress Notes revealed the following:<br><br>-On 9/23/25, R1 complained of right side back pain near their ribs. No bruises or marks were observed in the area. R1 was offered pain medications and R1 declined.<br><br>-On 9/24/25, R1 was seen by her primary doctor and R1 denied having any questions or concerns.<br><br>-On 9/26/25, R1 has had an increase in reporting and signs of lower back/rib pain. R1 had been given as needed Tylenol more frequently as well due to right lower back/rib pain. Family requested that R1 have an x-ray completed. May we have orders for portable x-ray services to come to facility and do 2 views of the right side of the ribs and lower back, to rule out any | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 10<br>possible fractures. Please advise.<br><br>-On 9/26/25, R1 had a fall in the hallway. R1 was very angry and agitated, the hall was calm, area clean. R1 had landed on her left side and did not hit her head. No apparent injuries were noted and R1 denied pain. R1 had a near fall 30 minutes prior to this fall and the nurse had to lower R1 to the floor. R1 walks very fast when she was angry and her right left noted to give way and fell to the left. R1 would not allow for nurse to observe her skin or obtain vital signs. R1 was assisted to sit in her recliner then later assisted to recliner in commons area to keep resident within view.<br><br>-On 9/27/25, portable x-ray services called to come to facility and x-ray R1's lumbar spine and right ribs.<br><br>-On 9/29/25, family meeting R1 at the clinic for an appointment<br><br>-On 9/29/25, call placed to radiology department, no results yet from imaging performed to resident's arm today.<br><br>-On 9/30/25, family called to report she had set up an appointment for 9/30/25 for a follow up orthopedics appointment related to R1's x-ray results.<br><br>-On 9/30/25, R1 had x-ray done to the left elbow and shoulder. Results will be faxed over from radiology.<br><br>-On 10/1/25, spoke with clinic and orthopedic specialist and appointment scheduled to apply splint to left arm.<br><br>-On 10/2/25, physician visit note revealed assessed pain in left upper extremity, noted left elbow skin tear and left elbow radial head fracture.<br><br>-On 10/3/25, R1 complained of hurting all over and an ice pack was applied to left arm.<br><br>-On 10/4/25, R1 was agitated and wanting to go home, complained of pain. R1 observed by staff member attempt to stand without assistance, because she wanted to go home, R1 was assisted to wheelchair due to weakness and previous fall with fracture to left arm.<br><br>-On 10/5/25, R1had a fall in resident's room. R1 was observed to be sitting on the floor next to her bed and her back was resting on the bed. R1 had an existing left arm fracture, and no other injury was noted. R1 had been agitated all evening wanting to go home. R1's bed was in lowest position, frequent checks were | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 11<br>performed, and one to one staff was implemented.<br><br>-On 10/5/25, R1 was transferred to the ER and admitted to the hospital.<br><br>R1's progress notes lacked evidence of IDT root cause analysis following two falls on 9/26/25 and the one fall on 10/5/25. In addition, there also was not evidence of new interventions implemented to prevent future falls and injuries.<br><br>R1's Patient Report, from portable x-ray company, dated 9/28/25, indicated R1 had pain after fall and findings included right lateral 8th and 9th rib fractures.<br><br>R1's Office Visit note dated 10/2/25, indicated R1 had multiple falls recently last week. R1 had an x-ray of her left elbow that showed a radial head fracture, which was nondisplaced. R1 was referred to our office for definitive management of the fracture. The patient right now states there was no pain over the elbow and denied range of motion deficits of that elbow. However, there was a skin tear of the left elbow.<br><br>On 10/15/25 at 1:06 p.m., family member (FM)-A stated R1 would have frequent falls and R1 would not always report her falls to the staff at the facility. FM-A stated she was not aware of interventions the facility staff were attempting to prevent falls other than there was a sign on R1's walker. Further, FM-A stated R1 had three falls in a short period of time and R1 did sustain fractures of the ribs and elbow from the falls.<br><br>On 10/15/25 at 2:51 p.m., LPN-B stated R1 had impaired cognition and would often become agitated and attempt to leave and exit seek in the evenings. When R1 would exhibit these behaviors, LPN-B stated R1 would often lose her gait and had falls. LPN-B stated R1 was at risk for falls and R1 had reported falls to her granddaughter that R1 had not reported to staff before. LPN-B stated she was working when R1 had the two falls on 9/26/25, and following the falls LPN-B stated staff were "watching her closely" as an intervention but was not aware of any care plan changes for long term interventions following those two falls. Further, LPN-B stated she was also working on the 10/5/25 fall and R1 did not complain of pain at the time but had a pre existing left arm fracture, and staff were completing frequent checks through out the night and again LPN-B could not recall any new interventions implemented following that fall as R1 was admitted to the hospital and returned to the facility on Hospice services. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 12<br>On 10/15/25 at 3:21 p.m., NA-A stated R1 was at risk for falls and NA-A stated “I don’t think we really had many to be honest” when asked what interventions staff would implement to prevent R1 from falling. NA-A stated R1’s door to her room would be kept open and staff would check on her and assist with cares as needed. NA-A stated she was working the overnight on 10/5/25, and at approximately 1:00 a.m. NA-A found R1 on the floor and R1 was last seen at 11:30 p.m. sleeping in her bed.<br><br>On 10/16/25 at 11:49 a.m., NA-B stated R1 exhibited behaviors of wandering and attempted to escape out of the doors. NA-B stated R1 was identified as a fall risk and stated, “she didn’t have many interventions for falls”, and staff were directed to keep R1 close to the nursing station, bring her to activities, and R1 had a toileting schedule. Further, NA-B stated fall interventions were in the resident’s care plan for staff to reference.<br><br>On 10/16/25 at 12:51 p.m., NA-C stated R1 appeared to be more confused in the afternoon into the evenings and R1 often would express wanting to go home. NA-C stated staff would attempt to redirect her, offer activities, assist with walking, or provide a one-to-one staff to de-escalate behaviors. NA-C stated R1 was at risk for falls and staff were directed to leave walker within reach, keep room door open, and had a toileting program. Further, NA-C stated R1 has sustained rib fractures and an arm fracture from recent falls.<br><br>On10/16/25 at 3:42 p.m., RN-A stated R1 appeared to be confused and would attempt to exit seek and self-transfer. RN-A stated R1 was at risk for falls and interventions included assist R1 with nighttime care, transfer to her bed between 9-10 p.m., toileting schedule, walker with a sign attached, appropriate footwear while ambulating and keep her call light within reach even though she would not utilize her call light. RN-A stated R1 had two falls that occurred on 9/26/25, the first fall was due to weakness and the second fall was R1 lost her footing. RN-A stated she reviewed both falls and the long-term intervention was to have R1 out in the recliner in the commons area within view, however RN-A could not give further detail on when staff would be directed to implement this intervention, and the intervention was not communicated to staff and R1’s care plan was not revised. Further, RN-A stated the root cause for R1’s fall on 10/5/25 was R1 was agitated all evening and refusing care, and RN-A stated there was no long-term intervention implemented due to R1 being transferred to the hospital and returning to the facility on hospice. In addition, RN-A | F0689 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GLENWOOD VILLAGE CARE CENTER | 719 SOUTHEAST 2ND STREET , GLENWOOD, Minnesota, 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 |
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| F0689 SS = SQC-J | Continued from page 13<br>stated facility process for falls included RN-A reviewing each fall and determining a root cause, and reviewing the immediate intervention staff implemented for appropriateness and adjusting intervention if not appropriate. RN-A confirmed a RN follow up note which would include the root cause analysis of the fall, IDT input, and a new intervention was not completed for R1's three falls per facility protocol.<br><br>On 10/16/25 at 4:49 p.m., DON stated R1 had a fall at the end of September in the hallway and R1 did not have any injuries at the time. DON stated R1 had self-reported a fall to staff and she was having pain, however there were no reports of R1 having a fall and DON was questioning if R1 had fallen into something. R1 obtained x-rays which revealed rib fractures and an elbow fracture. DON stated R1 had another fall from her bed and was sent to the hospital and returned on palliative care. Further, DON stated the nurse manager on the unit would be responsible for reviewing each fall and completing a follow up note with an intervention. DON stated the floor staff would be expected to implement an immediate intervention until the nurse manager reviewed the fall and determines an appropriate intervention and then updates the resident's care plan and communicates revisions in the nurses' report.<br><br>On 10/16/25 at 5:29 p.m., surveyor receive email from DON which revealed: After reviewing the fall that occurred on 9/26, it was noted that the nurse on duty implemented an intervention to keep the resident within view in the common area. However, upon further review with the nurse manager responsible for the resident at the time, it was identified that an RN fall follow-up was not completed. We will be proceeding with progressive counseling for the RN regarding this incident and will provide education to all staff on appropriate fall interventions during our next team meeting on 10/29.<br><br>On 10/17/25 at 9:48 a.m., DON stated prior to R1's fall on 9/26/25, R1 had been reporting she fell but there was no bruising noted to the area. On 9/26/25, there was a progress note regarding increased rib pain. DON stated she was made aware of R1's rib fractures on 9/29/25, and DON stated she was assuming R1 had fallen against something because there was no evidence of other falls. DON stated she interviewed a couple of the nurses who were not aware of any additional falls, and DON stated she should have investigated the fractures more following that. Further, DON confirmed R1's two falls on 9/26/25, did not have evidence of a RN | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 14<br>follow-up note or new interventions implemented to prevent future falls. DON stated R1 had an x-ray of her arm following the fall on 9/26/25, and DON reviewed the radiology report and interpreted as not being a definite fracture but more than likely the fracture would have been associated with R1's fall. DON confirmed R1's fall that occurred on 10/5/25, did not have an RN follow-up completed either with a root cause analysis or new intervention.<br><br>On 10/16/25 at 11;06 a.m., LPN-C stated R1 would exhibit sundowning behaviors and want to leave the facility and R1 would be challenging to redirect. LPN-C recalls R1 reporting she had fallen but there was no documentation by staff of any other falls because no staff had found her, R1 just kept reporting she fell.<br><br>On 10/16/25 at 11:19 a.m., NA-G stated R1 had impaired cognition and was at risk for falls. NA-G stated staff were assuming R1 was falling and not reporting the falls to staff. NA-G stated she had heard noises coming from R1's room but upon arrival R1 was not on the floor and R1 would deny a fall.<br><br>On 10/21/25 at 10:42 a.m., attempted interview with R1's physician unsuccessful.<br><br>Review of facility policy titled Fall Prevention and Management revised 6/11/25, defined an intercepted fall as when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person, this would still be considered a fall. Further, policy revealed clinical manager was responsible for implementation and oversight of individualized residents fall prevention care as follows: collaborating with the IDT in the prevention of falls, appropriately managing resident who experience a fall by implementing interventions to prevent further falls, and care plan would be updated to reflect individual needs for safety. The new intervention would be monitored for effectiveness every shift for 48 hours after implementation notation of effectiveness should occur in the medical record. | F0689 | | |