Electronically delivered
March 9, 2021

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

RE: CCN: 245360
Cycle Start Date: February 18, 2021

Dear Administrator:

On February 18, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On February 8, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC) (Delete if not SQC and this note)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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, Glenoaks Senior Living Campus is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effectiveFebruary 18, 2021. 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.

DEPARTMENT CONTACT

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

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

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 02/18/2021

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

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F 000	INITIAL COMMENTS On 2/16/21-2/18/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5360032C (MN00069874, MN00069896) with a deficiency cited at F689 at Past Non-Compliance. The IJ began on 2/8/21, at 6:40 a.m. when R1 was discovered by staff to be laying on the radiator heater and found second and third degree burns to R1's right thigh, calf and two feet. R1 was sent to the emergency department for monitoring and treatment of burns. The administrator and director of nursing (DON) were notified of the IJ on 2/17/21 at 4:59 p.m. However, the IJ was removed and the deficient practice corrected on 2/8/21, prior to the start of the survey and was therefore a Past Noncompliance. The above findings constituted substandard quality of care (SQC), and an extended survey was conducted on 2/18/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2021

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess and implement interventions to prevent a hazard free environment for 1 of 3 residents (R1) reviewed for accidents after moving R1 to a new room, whose bed was historically positioned against the wall for safety, and then whose bed was placed against a radiator heater. This resulted in actual harm to R1 who required medical treatment at the emergency department when he obtained 11 burns between the right thigh and calf and on both feet from a radiator heater while in bed. This failure resulted in an immediate jeopardy (IJ). The IJ began on 2/8/21, at 6:40 a.m. when R1 was discovered by staff to be laying on the radiator heater and found second and third degree burns to R1's right thigh, calf and two feet. R1 was sent to the emergency department for monitoring and treatment of burns. The administrator and director of nursing (DON) were	F 689	Past noncompliance: no plan of correction required.	3/9/21

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F 689	Continued From page 2 notified of the IJ on 2/17/21 at 4:59 p.m. However, the IJ was removed and the deficient practice corrected on 2/8/21, prior to the start of the survey and was therefore a Past Noncompliance. Findings include: R1's current diagnosis according to an updated face sheet dated 2/17/21, indicated diagnoses of Parkinson disease, dementia without behavioral disturbance, major depressive disorder, kidney disease. R1's significant change Minimum Data Set (MDS) dated 12/30/20, included cognitive skills severely impaired, bed mobility was total dependence with a two person physical assist, always incontinent of urine and bowel. R1's Care Area Assessment (CAA) dated 12/30/20, indicated cognitive impairment, confusion, dementia and Parkinson disease, difficulty making self-understood, difficult understanding others, totally incontinent of urine requiring staff to continue with check and change every 2 hours and monitor for changes in condition, total dependent of staff for all mobility uses a ceiling lift/Hoyer lift for all transfers, history of falls mostly related to rolling out of bed. R1's care plan dated 8/6/20, identified, FALL RISK: high risk for falls; history of falls; is no longer ambulatory; Hoyer lift/ceiling lift for all transfers and totally dependent of staff for all mobility. Also identified, at risk for falls related to progressive Parkinson's along with Lewy body dementia; bowel and bladder incontinence; medications; chronic pain related osteoarthritis of knee and impaired functional range of motion	F 689		

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lower extremities related to Parkinson's. R1 does not communicate needs and has history of rolling out of bed. R1's goal was to be free from falls with no major injuries. Interventions included auto lock brakes on resident's bed, toileting per elimination plan of care, total assist of two with full body lift for all transfers and to turn and reposition in bed. Added on 2/9/21, was "When positioning on side avoid over position to prevent him from rolling over." Added on 2/17/21, "Keep bed in lowest position. Bed must not be positioned against walls or against wall heater at any time. Headboard of bed should be positioned with the headboard of the bed in line with the light fixture on the wall." Added on 2/17/21, "Place fall mats on floor on both sides of bed when resident is lying in bed. Keep bed in lowest position while resident is lying in his bed to ensure safety."

R1's incident report dated 2/8/21, at 6:40 a.m. included, "Resident was sleeping in bed in low position. Bed was in proximity to heat register on the wall. Between nursing rounds, resident rolled self close to heat register. During the next nurse round, the nurse noticed this and moved resident and bed immediately away from heat register. Nurse evaluated and found resident to have burns on right leg and both feet. Resident's call light was not on and did not call out for staff that they were in pain. Resident sent to ER for further evaluation."

R1's progress note dated 2/8/21, at 6:40 a.m. included R1 to be sent to emergency room in Willmar. Ambulance called and resident left the facility at 6:07 a.m. to Rice Hospital ER to evaluate R1's burns.

R1's Emergency Department Provider Notes from

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Rice Memorial Hospital dated 2/8/21, included, "Pt [patient] comes from Glen Oaks NH by ambulance. Staff is not sure how long pt laid by the register by they had checked him 2 hours prior and he was still in bed. Pt is disoriented at baseline and unable to offer any information. Burns to right lateral lower extremities (LE) and medial left foot. Pt reports pain to both ankles when he does speak but this was inconsistent."

R1's Wound Ostomy Continence (WOC) Outpatient Clinic, Carris Health-Rice Memorial Hospital dated 2/8/21, exam included, "His right lower extremity is assessed. To the right lateral thigh and right lower leg is an area of partial thickness burn which measures 61 x 8 cm (centimeter) over the lateral thigh most proximal is a serous blister measuring 5.5 x 4.5 cm. There is a serous blister distal to this measuring 1.5 x 2 cm. Most distal and lateral is a serous filled blister measuring 0.8 x 1.4 cm. Over the fifth metatarsal head is a full thickness burn measuring 0.5 x 1 cm. There is surrounding irritation measuring 1.5 x 1.5 cm. Over the lateral leg distal to knee is an area of full thickness burn measuring 3.5 x 2 cm. The left lower extremity is assessed. There is a full thickness burn to the great metatarsal head measuring 4 x 4.2 cm. To the left great toe distal is an area of erythema measuring 1.1 cm. Over the mid foot is a burn measuring 1.2 x 1.1 cm. There is a faint erythema of the mid foot measuring 18 x 6 cm. The wounds are cleansed with saline. R1 was sent back to nursing home and not admitted to the hospital."

When interviewed on 2/16/21, at 9:30 a.m. the administrator stated following the incident, the facility developed a plan of correction immediately on 2/8/21. The plan titled, Glenoaks Abatement

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Plan was dated, 2/8/21 was reviewed with the administrator and stated all the beds in the facility were audited for their location in the rooms and temperatures of the heaters, all nursing staff were educated on positioning beds safely away from the heaters and all residents care plans were audited. The administrator further explained the beds should be positioned center of the light fixture which is a safe distance from the heater and an ongoing audit of bed position would be conducted. Administrator stated the facility consulted an engineer on 2/8/21, which concluded due to extreme low temperatures the boiler could have "over worked" and raised the temperature levels. Administrator stated an ongoing temperature audit of the heaters of all the rooms were also initiated and will be conducted throughout winter months.

It was observed on 2/16/21, at 12:09 p.m. R1 in bed resting, bed was low to the ground and was approximately two to three feet away from the radiator heater. A night stand was observed as a barrier between the bed and radiator heater. Mats on the floor were also observed.

When interviewed on 2/16/21, at 12:19 p.m. health information coordinator (HIC)-A stated, previous to R1's recent injuries R1's bed was known to be right next to the heater to help with falls. HIC-A stated R1 could become "wiggly" and believed R1 moved toward that side and the mattress pushed him over to the heater.

During observation and interview on 2/16/21, at 1:15 p.m. R1's burns (first to third degree on leg) were observed to be in varying stages of healing. R1's bilateral feet had dressings intact and were unable to be observed. While completing the

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dressing change, ADON stated R1 had a follow up appointment today with WOC. ADON stated R1 had noticeable pain when someone would "mess" with his burns and the doctor had ordered Tramadol which had been effective. ADON stated she was not working when incident occurred but recalls R1's bed had always been against a wall to help keep him from rolling out of bed. ADON is not aware of any assessments completed regarding risks of R1's bed against the heater. ADON did not recall R1's care plan indicating the position of the bed to be against a wall.

When interviewed on 2/16/21, at 1:24 p.m. nursing assistant (NA)-A stated R1's bed was always against a wall. NA-A stated R1 was in a different room previously and had his bed against a wall but not against the heater. NA-A stated when R1 moved to his current room R1's bed was moved to be against the wall where the heater was. NA-A stated she was not aware of an assessment completed when R1 changed rooms to look at the risks for his bed to be next to a heater. NA-A state R1's care plan instructed to have his bed at a low position but did not recall R1's bed to be against a wall.

When interviewed on 2/16/21, at 1:34 p.m. administrator stated R1 previous room had his bed positioned against a wall, however it was an interior wall and the heaters were not located there. Administrator stated he was not sure why R1's current room had his bed against the wall where the heater was. Administrator stated he was not aware if there was an assessment completed addressing risks for the positioning of R1's bed. Administrator stated he was not aware if R1 or his family wanted his bed against the wall with the heater.

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When interviewed on 2/16/21, at 1:52 p.m. by phone, family member (F)-A stated R1 had a history of rolling out of bed. F-A stated she knew R1's bed was against a wall in his previous room but did not recall it being against a heater. F-A stated R1 moved rooms during a COVID outbreak and had not seen his room due to visitor limitations. F-A stated the family did not request his bed be against a wall and was not aware his current room had his bed positioned against a heater. F-A stated her understanding for R1 to be against a wall due to his history of rolling out of bed. F-A stated she feels the facility reacted competently and acted to get R1 the care he required once the burns were discovered.

When interviewed on 2/16/21, at 2:22 p.m. the environmental director (ED) stated the investigation started on 2/8/21, regarding R1's burns and if there was a malfunction with the heater. ED stated the administrator and ED checked the temperature of R1's heater and positioned his bed away from the heater. ED stated the heater is approximately six feet long located on the exterior wall. ED stated the head of the bed that was parallel to the heater recorded a temperature of 80-90 degrees Fahrenheit. When the middle of the 6-foot heater was checked is recorded a temperature of 122 degrees Fahrenheit. ED stated the facility consulted with an engineer for potential remedies for the radiator running inconsistently. The engineer reported the heaters in the facility are designed to be safe to touch and a temperature of 115 degrees Fahrenheit and under will not burn skin. ED stated the natural cold weather was also a factor, temperatures that morning on 2/8/21, were below 20 degree Fahrenheit and the

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boiler was working "overtime." ED stated R1's heater has dampers and upon investigation the dampers were positioned in the wrong direction, blowing the heat all to the top of the heater on the metal. ED stated R1's bed was against the heater and in his previous room his bed was positioned against a wall. ED stated when R1 moved to his current room it was overlooked, the heater piece, because R1 bed was positioned against the wall in his prior room.

When interviewed on 2/16/21, at 2:44 p.m. NA-B stated R1's bed is positioned at the lowest level when he is in bed and the bed is put up against the wall. NA-B stated R1 does "wiggle" a lot in bed and was not surprised he could do this himself. NA-B stated his bed was known to be against the heater. NA-B stated she thought the heaters did not get that hot to burn so bad. NA-A stated R1 is repositioned every two hours even during sleeping hours due to R1 being incontinent.

When interviewed on 2/16/21, at 3:31 p.m. phone call with NA-C stated she discovered R1 burns. R1 is a check and change every two hours, even during sleeping hours. NA-C stated she checked on R1 at 11:30 p.m., 1:30 a.m., and at 3:30 a.m. NA-C stated he was positioned on his right side. NA-C stated between 4 a.m. or 5 a.m. that is when they discovered R1's right leg was on the heater and his left leg was over his right leg and both feet were touching the heater. NA-C added, R1 would usually yell out if he was in pain or needed help, but he never did that on 2/8/21. NA-A stated the nurse was called immediately to assist. NA-C stated she touched the heater and it was hot and had to remove her hand in less than a minute. NA-C stated R1's bed had been up

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F 689	Continued From page 9	F 689		

against the wall in his previous room. NA-C state R1's care plan did not state to have his bed against the wall.

When interviewed on 2/17/21, at 5:56 a.m. phone call with licensed practical nurse (LPN)-A stated she was the nurse who discovered R1's burns along with nursing assistants. LPN-A stated she checked on R1 at 4:15 a.m. and R1's leg was not against the heater. LPN-A stated it was around 5 a.m. when the nursing assistants were doing their last rounds. LPN-A stated when R1 was found to have burns his bed was positioned farther away from the heater immediately. LPN-A assessed R1's skin and discovered the burns. LPN-A stated R1 did not appear to be in pain when found. LPN-A did touch the heater and stated it was too hot and had to pull away her hand. LPN-A stated she called facility administration, family and R1's doctor and the plan of care was to send R1 to hospital by ambulance.

When interviewed on 2/17/21, at 10:08 a.m. director of nursing (DON) stated R1's bed was positioned against the heater during this incident and she was unsure why his bed was positioned by the heater. DON stated there was no assessment completed when R1 changed room. DON stated R1's previous room the bed was positioned against an interior wall and the heater was not located on that wall. DON stated she was not aware R1's care plan stating his bed should be against the wall especially against the heater. DON stated when R1 moved it is not known why is bed was placed by the heater, no assessment was completed or intervention for R1's safety to have his bed positioned against the heater.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 02/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 On 2/17/21, at 9:20 a.m. the administrator provided two new policies dated 2/16/21, titled: Heat Register Safety and Resident Bed Placement policy. Heat Register Safety stated the purpose was "to ensure heat registers are kept at a safe temperature to prevent potential harm to residents, staff, or visitors". Resident Bed Placement Policy stated the purpose was "to ensure residents are free from unnecessary restraints or any other hazards regarding the placement of their bed within their living space". Interviews on 2/17/20, were completed with various staff positions which all verified education was received the day of the incident about where to position beds, away from the heater. On 2/17/21, it was observed at 2:10 p.m. R1 in bed approximately two to three feet away from the heater, bed was in low position with mats on both sides of R1's bed. On 2/17/21, all resident rooms were observed between 2:15 p.m. and 3:00 p.m. to confirm bed placement was positioned safely away from heater and per policy. No concerns were identified. The past non-compliance IJ which began on 2/8/21, was removed prior to the abbreviated survey due to multiple action(s) taken by the facility to correct the identified non-compliance. These actions included a review and revision of the facility's policy and procedure related to environmental safety, heater temperatures, bed positioning in resident rooms and care plan audits. Additionally, R1 and all resident served had bed placement and heat elements audited for	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 02/18/2021

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

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F 689	Continued From page 11 safety and ongoing audits were put into place and all staff were verified to be trained on new policies. As a result, the IJ was removed and the identified non-compliance was corrected as of 2/8/21.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 9, 2021

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

Re: Event ID: 8XXV11

Dear Administrator:

The above facility survey was completed on February 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	C 02/18/2021

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/16/21 - 2/18/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED:	2 000		

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

Electronically Signed | 03/09/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 H5360032C (MN00069874, MN00069896) -No licensing orders were issued due to actions taken by the facility prior to entrance.	2 000		