| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245263 | A. Building<br>B. Wing | 06/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glenfields Living With Care | 2015 Hennepin Avenue North<br>Glencoe, MN 55336 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the care plan included management and monitoring of anticoagulant (blood thinner) therapy for 2 of 3 residents (R30, R66) reviewed for anticoagulants.<br><br>Findings include:<br><br>R30's annual minimum data set (MDS) dated [DATE], indicated cognitively intact. R30 had diagnoses of atrial fibrillation (an irregular heart rate that commonly causes poor blood flow), hypertension (high blood pressure), and history of cerebral infarction (stroke).<br><br>R30's electronic medical record (EMR) included an order for Eliquis (a blood thinner) 5 milligrams (mg) twice a day, with a start date of 7/4/23. However, failed to include an order to monitor for potential side effects or signs ob bleeding due to Eliquis use.<br><br>R30's care plan last revised 5/20/25, failed to include anticoagulants or to monitor for side effects of the medication.<br><br>R66's admission MDS dated [DATE], indicated severe cognitive impairment. R66 had diagnoses of hypertension (high blood pressure), diabetes, Alzheimer's disease (a condition that affects memory, thinking, and behavior), and history of cerebral infarction (stroke).<br><br>R66's order summary report dated 6/5/25, included an order for warfarin sodium 10 milligrams (mg) ever Wednesday and Saturday and warfarin sodium 7.5 mg every Monday, Tuesday, Thursday, Friday and Sunday. Order Summary Report failed to include an order to monitor for potential side effects or signs of bleeding due to warfarin use.<br><br>R66's undated care plan failed to include he took anticoagulants or to monitor for side effects of the medication.<br><br>During interview on 6/4/25 at 9:29 a.m., registered nurse (RN) case manager (CM)-C stated nursing would review a resident's medication list to know if anyone was on an anticoagulant. CM-C stated nursing assistants (NA) do not have access to the medication list but should report any signs of bleeding to a nurse because that would be abnormal.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 6/5/25 at 8:53 a.m., consultant pharmacist (CP) stated he reviewed charts during monthly pharmacy reviews to look for any necessary labs and interactions. The CP stated he expected monitoring for bruising and bleeding. The CP also stated it would be important to be aware when someone was on a blood thinner because they would be more prone to bleeding with routine dental care.<br><br>During interview on 6/5/25 at 9:42 a.m., the director of nursing (DON) stated nursing assistants should monitor for bruising and update nursing when needed. Nursing should watch for bruising and other side effects of anticoagulants. The DON stated the care plan should include when a resident was on an anticoagulant.<br><br>Undated facility policy for anticoagulants use failed to address monitoring for anticoagulants. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to update the primary care physician (PCP) with significant weight gain for 1 of 1 residents (R66) reviewed for nutrition.<br><br>Findings Include:<br><br>R66's admission Minimum Data Set (MDS) dated [DATE], included R66 had severe cognitive impairment. R66 had diagnoses of hypertension (high blood pressure), diabetes, Alzheimer's disease (a condition that affects memory, thinking, and behavior), and obstructive sleep apnea (a collapse or closure of the airway during sleep). R66's weight was recorded at 252 pounds (lbs).<br><br>According to R66's electronic medical record (EMR) on 02/12/2025, R66 weighed 252.0 lbs. On 05/28/2025, R66 weighed 292.0 pounds which was a 15.87 % gain.<br><br>R66's weight change note dated 2/26/25, included a weight warning that was not likely nutrition related and that the nurse manager was notified to follow up.<br><br>R66's health status note dated 3/8/25, included R66 had audible wheezing and a 13 lb weight increase since 2/2/25. No update to PCP was noted.<br><br>R66's weight change note dated 5/8/25, included a weight warning of 288 lbs and that note was likely not nutritionally related. RN was updated for fluid status evaluation.<br><br>R66's weight change note dated 5/21/25, included a weight warning and that note was likely not nutritionally related. RN was updated for fluid status evaluation.<br><br>R66's care conference note dated 5/23/25, included weight fluctuations likely fluid related and that RN was notified of weight change.<br><br>R66's health status note dated 5/24/25, included a respiratory and edema assessment. No update to PCP was noted.<br><br>During interview on 6/4/25 at 9:33 a.m., registered nurse (RN) case manager (CM)-C stated the registered dietitian (RD) monitored weights and updated nursing with an email when there was a weight gain concern. CM-C stated nursing did a cardiac assessment and updated the provider after the RD noted a weight increase concern. CM-C confirmed a cardiac assessment was noted on 5/24/25. CM-C confirmed R66 had a 40 lb weight increase since admission and the provider should have been updated with the increase, but was not.<br><br>During interview on 6/4/25 at 8:06 a.m., RD stated she monitored weights weekly and checked in with nursing and the homemakers to see if they have noticed any changes. The RD stated she depended on them for updates on changes because they were there daily. RD stated she noticed an increase in R66's weight and, after reviewing intakes and rate of increase, she felt it was possibly related to fluid retention. RD stated her process was to send an email to update nursing, along with putting a progress note into the resident's chart. The RD confirmed she sent two email updates, one on 5/8 and one on 5/23 to update nursing on the weight concern.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Email from RD to CM-C dated 5/8/25 included R66 had ongoing significant weight gain, with a gain of 13 lbs in 7 days that was not likely related to nutrition.<br><br>Email from RD to CM-C dated 5/21/25, included R66 had a 24 lb weight gain in the last 30 days and was not likely due to nutrition. Email included a request to monitor fluid status change.<br><br>During interview on 6/5/25 at 9:48 a.m., the director of nursing (DON) confirmed weights were obtained weekly on bath day unless otherwise ordered by a provider. Weights were monitored by the RD and updated nursing with any increase thought to be medially related. The DON stated she expected nursing to follow up with a cardiac assessment and review of potential reasons for increase. The DON confirmed a 40 lb weight gain since admission would have been a significant increase and she expected nursing to update the PCP for follow up. The DON stated it was important to update the PCP with weight increase because there may be a medical reason that was not being addressed.<br><br>Facility policy for weight monitoring dated 2/11/22, included nursing assistants (NA) are to obtain weights on bath days. The NA should review previous weight and if the weight had changed by 3 lbs in a week or 5 lbs in a month, the weight should be rechecked immediately. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently offer range of motion (ROM) and exercises for 1 of 1 residents (R8) reviewed for restorative nursing program.<br><br>Findings include:<br><br>R8's admission Minimum Data Set (MDS) dated [DATE], included R8 was cognitively intact, able to make self be understood, and able to understand others. R8 had a diagnoses of stage 4 pressure ulcer on her sacral region (a wound caused by pressure extending to underlaying tissue like muscle, bone or tendon), multiple sclerosis (MS)(a disease that can cause weakness, pain, fatigue and impaired coordination), and malnutrition (a lack of proper nutrition).<br><br>During interview on 6/2/25 at 1:11 p.m., R8 stated she was supposed to get ROM exercises, but staff do not always offer them to her. R8 wanted to complete ROM exercises because she knew it was important to prevent weakness from MS.<br><br>R8's task documentation for restorative program - exercise orders for dates 5/15/25 to 6/4/25, included 12 yes responses, 3 no responses, and 26 not applicable responses. R8's task documentation for Restorative Program - other for dates 5/6/25 to 6/4/25, included 19 yes responses, 2 no responses, and 38 not applicable responses. R8's task documentation for Restorative Program - ROM for dates 5/6/25 to 6/3/25, included 9 yes responses, 4 no responses, and 45 not applicable responses.<br><br>Progress notes dated 6/2/25, 5/28/25, 5/19/25, 5/11/25, 5/5/25, 4/27/25, 4/23/25, and 4/17/25, included a summary of restorative activity for the week. Progress notes included a therapy referral would not be submitted due to there being ample opportunities for staff to offer the program.<br><br>During interview on 6/4/25 at 10:20 a.m., nursing assistant (NA)-A stated ROM exercise were listed on a restorative list and documented in the electronic charting system. NA-A stated a refusal slip needed to be filled out when a resident refused. NA-A stated she documented not applicable when the task was not offered or completed on that shift because of not having time.<br><br>During interview on 6/4/25 at 10:28 a.m., NA-B stated restorative and ROM tasks were documented in the electronic charting system and on restorative papers. NA-B stated she marked not applicable when she did not offer the task to the resident.<br><br>During interview on 6/5/25 at 8:17 a.m., director of therapy (DOT) stated therapy was involved in creating restorative nursing programs. DOT stated she expected an update if the restorative program was not completed as ordered for any reason, including when it was not offered. DOT stated she spoke with R8 recently and R8 stated she wished to continue with the restorative programs as ordered. DOT stated completing the restorative program and ROM exercises was important to prevent decrease in mobility and prevent falls.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 6/5/25 at 9:57 a.m., director of nursing (DON) stated the registered nurse care coordinators monitored the restorative task completion weekly and documented with a progress note. The DON expected follow up with the NA team to find out why the task was not completed. DON stated when not applicable was charted, it meant the task was not completed on that shift. The DON stated the restorative progress notes indicated the program was not offered. The DON stated the resident was at risk for deconditioning and decline in ability if the program was not being offered and completed.<br><br>Undated facility policy for repositioning included a restorative program would be designed according to the resident's goals, ability and desires. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed for 2 of 2 residents (R8, R63) observed for wound care and failed to properly implemented enhanced barrier precautions (EBP) for 4 of 4 residents (R8, R63, R66, R73)) reviewed for contact precautions.<br><br>Findings include:<br><br>R8's admission Minimum Data Set (MDS) dated [DATE], included R8 was cognitively intact, was able to make self be understood and was able to understand others. R8 had a diagnosis of stage 4 pressure ulcer on her sacral region (a wound caused by pressure extending to underlying tissue like muscle, bone or tendon), multiple sclerosis (MS)(a disease that can cause weakness, pain, fatigue and impaired coordination), and malnutrition (a lack of proper nutrition).<br><br>During observation on 6/4/25 at 10:38 a.m., registered nurse (RN)-A completed wound care on R8. RN-A washed hands with soap and water and applied gown and gloves prior to starting wound care. RN-A removed soiled dressing and cleansed wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A cleansed second wound as ordered. RN-A removed gloves, washed hands with soap and water and applied new gloves. RN-A packed first wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A packed second wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A placed a clean dressing as ordered to both wounds. RN-A changed gloves but did not complete hand hygiene. RN-A started wound care on wound to R8's thigh by removing soiled dressing. RN-A changed gloves but did not complete hand hygiene. RN-A cleansed wound as ordered. RN-A changed gloves but did not complete hand hygiene. RN-A completed wound care to thigh by applying new clean dressing. RN-A completed hand hygiene with soap and water and applied clean gloves prior to completing wound care on ankle wound. RN-A removed soiled dressing and changed gloves without completing hand hygiene. RN-A cleansed wound and completed wound care as ordered. RN-A removed gloves and washed hands with soap and water.<br><br>During interview on 6/4/25 at 11:23 a.m., RN-A stated hand hygiene should be completed prior to starting wound care, any time you remove a soiled dressing and when wound care is completed. RN-A stated she had been taught to complete hand hygiene every time gloves were changed, but did not feel it was necessary to complete hand hygiene as frequently during wound care and does not complete it every time she changes her gloves. RN-A stated changing gloves was not a substitute for hand hygiene.<br><br>R63's admission MDS dated [DATE], included R63 had an admission date of 4/14/25. R63 was cognitively intact and had diagnoses of diabetes with skin complications, peripheral vascular disease (a condition that narrows blood vessels and reduces blood flow to limbs), multidrug-resistant organism (MDRO), and a surgical wound without normal wound healing.<br><br>During observation on 6/4/25 at 10:00 a.m., RN-B completed wound care for R63. RN-B completed hand hygiene, applied gown and gloves prior to starting wound care. RN-B removed soiled dressing and changed gloves. RN-B did not complete hand hygiene. RN-B cleansed wound as ordered. RN-B did not complete hand hygiene or change gloves. RN-B completed wound care and completed hand hygiene upon completion.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview on 6/4/25 at 12:15 p.m., RN-B stated she completes hand hygiene prior to starting wound care and after completion of wound care. RN-B stated she would not wash her hands at any other time, except if she was moving from one wound to another.<br><br>During interview on 6/4/25 at 11:29 a.m., charge nurse RN-C stated the expectation was for staff to wash hands with soap and water prior to starting wound care and upon completion. Hand sanitizer could be utilized with glove changes and when going from dirty to clean tasks.<br><br>During interview on 6/4/25 at 11:38 a.m., director of nursing (DON) stated hand hygiene was expected prior to starting wound care and when hands are visibly soiled. The DON stated she expected hand hygiene to be completed any time gloves were changed even if hands were not visibly soiled.<br><br>Facility policy for hand hygiene requested and not provided. Facility document for infection prevention included to perform hand hygiene immediately after removal of gloves.<br><br>EBP:<br><br>R8's admission Minimum Data Set (MDS) dated [DATE], included R8 was cognitively intact, was able to make self be understood and was able to understand others. R8 had a diagnosis of stage 4 pressure ulcer on her sacral region (a wound caused by pressure extending to underlying tissue like muscle, bone or tendon), multiple sclerosis (MS)(a disease that can cause weakness, pain, fatigue and impaired coordination), and malnutrition (a lack of proper nutrition).<br><br>During interview and observation on 6/2/25 at 1:14 p.m., R8 stated she had multiple wounds that staff completed daily wound care on. R8's room did not have any signage indicating R8 should be on precautions or storage for personal protective equipment (PPE) visible.<br><br>Facility document titled Negotiated Risk Agreement and Release signed 4/10/25, included R8 had a Foley catheter, ostomy, and open wounds and EBP was recommended with high-contact resident care per Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take.<br><br>During interview on 6/3/25 at 10:55 a.m., R8 stated she did remember the facility discussing the form with her, but felt it was presented as information and not as an option she could choose. R8 confirmed the staff do not wear a gown when working with her catheter, only gloves.<br><br>R63's admission MDS dated [DATE], included R63 had an admission date of 4/14/25. R63 was cognitively intact and had diagnoses of diabetes with skin complications, peripheral vascular disease (a condition that narrows blood vessels and reduces blood flow to limbs), multidrug-resistant organism (MDRO), and a surgical wound without normal wound healing.<br><br>During interview and observation on 6/2/25 at 6:37 p.m., R63 stated she had a diabetic ulcer on her foot and had wound care completed by staff. R63's room did not have any signage indicating R63 should be on precautions or storage for PPE.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Facility document titled Negotiated Risk Agreement and Release signed 4/14/25, included R63 had a diabetic foot wound and EBP was recommended with high-contact resident care per CDC and CMS guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take.<br><br>During interview on 6/3/25 at 10:28 a.m., R63 stated she did not remember reviewing the form and did not remember signing it. R63 confirmed she was admitted on [DATE] and recalled signing a lot of paperwork that day.<br><br>R66's admission Minimum Data Set (MDS) dated [DATE], included R66 had severe cognitive impairment. R66 had diagnoses of hypertension (high blood pressure), diabetes, Alzheimer's disease (a condition that affects memory, thinking, and behavior), and benign prostatic hyperplasia (enlargement of the prostate gland which can cause difficulty with urination).<br><br>During interview and observation on 6/2/25 at 4:21 p.m., FM-B confirmed R66 had a urinary catheter. R66's room did not have any signage indicating R66 should be on precautions or storage for PPE.<br><br>Facility document titled Negotiated Risk Agreement and Release signed 2/12/25, included R66 had an indwelling Foley catheter and EBP was recommended with high-contact resident care per CDC and CMS guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take.<br><br>During interview on 6/3/25 at 11:48 a.m., FM-B stated she did not remember reviewing the consent. FM-B stated she did not remember the facility discussing care of his catheter or risks.<br><br>R73's quarterly MDS dated [DATE], included R73 was rarely or never able to make self be understood and sometimes able to understand. R73 had diagnoses of dysphagia (difficulty swallowing) and had a gastronomy tube (g-tube)(a device that delivers nutrition directly to the stomach or small intestine).<br><br>During interview and observation on 6/2/25 at 2:01 p.m., family member (FM)-A confirmed R73 had a feeding tube. R73's room did not have any signage indicating R73 should be on precautions or storage for PPE.<br><br>Facility document titled Negotiated Risk Agreement and Release signed 10/1/24, included R73 had a g-tube and EBP was recommended with high-contact resident care per CDC and CMS guidance. The document described the potential negative outcomes to the resident and alternative plan to reduce the risk the facility would take.<br><br>During interview on 6/3/25 at 11:32 a.m., FM-A stated she did not recall being educated on precautions for R73's g-tube nor signing a consent form to waive EBP.<br><br>Undated facility provided document titled Enhanced Barrier Precautions (EBP) Lists included 20 residents. All 20 residents had yes under the column indicating they signed a negotiated risk agreement.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview on 6/4/25 at 1:01 p.m., DON confirmed the facility had identified 20 residents who qualified for EBP and all 20 had signed a negotiated risk agreement to opt-out of EBP. The DON stated it was the goal of the facility to provide a homelike environment and all of the residents who signed the form understood the risks. Conditions were reviewed at admission and periodically to ensure the facility was providing the necessary precautions. The DON confirmed the EBP negotiated risk form was not reviewed with residents who did not qualify for EBP.<br><br>During interview on 6/5/25 at 10:06 a.m., DON stated she was unsure how the EBP negotiated risk form was presented to residents, but everything on the form should be explained to the resident and their family. The DON stated there was a lot of information presented during admission and it would be hard to remember every piece of information presented.<br><br>Undated facility policy for enhanced barrier precautions, included an EBP risk assessment would be completed on all new admission and as needed to determine if EBP was recommended. If a resident decline or refuses EBP, a negotiated risk agreement would be signed by the resident or representative. |