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	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Senior Living Campus	100 Glen Oaks Drive New London, MN 56273

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview the facility failed to ensure 4 of 4 (R1, R5, R6 and R7) residents were treated with dignity and respect when care was provided to them by nursing assistant (NA)-PFindings include:Review of facility grievances identified a grievance dated 9/5/25, against NA-P made by R1, filled out by the director of nursing (DON). The grievance stated while DON was checking in on R1, R1 reported a nursing assistant for doing cares too fast. R1 identified NA-P. R1 further stated NA-P needed to slow down and I don't want her to help if that was even possible. DON reassured R1 she would speak to NA-P and R1 changed the topic.R1's significant Minimum Data Set (MDS) dated [DATE], identified no cognition deficits. R1 had history of falls, and diagnoses of fractured hip, chronic obstructive pulmonary disease (COPD), dependent on oxygen and dependent on staff to perform activities of daily living (ADLs) and used a wheelchair. R1 had verbal behaviors and rejection of cares.During an interview on 9/11/25 at 11:37 a.m., R1 identified NA-P to surveyor and stated when she knew NA-P was to assist her with cares, it increased her anxiety and caused her to act out. R1 further stated R1 made her feel worthless, during a subsequent interview on 9/11/25 at 2:07 p.m. R5's social service data collection tool dated 7/29/25, identified no cognitive deficits. R5 did not have any behaviors or rejection of cares.During an interview on 9/12/25 at 9:30 a.m., R5 stated NA-P could be rough during cares. Would prefer NA-P not work with her. During a subsequent interview on 9/12/25 at 1:45 p.m., R5 stated NA-P made her feel on edge, more anxious.R6's social service data collection tool dated 8/26/25, identified no cognition deficits, had no behaviors or rejection of cares.R6's face sheet date 9/12/25, indicated diagnoses of cerebral aneurysm, adjustment disorder with depressed mood, and history of cerebral infarct (stroke).During an interview on 9/11/25 at 3:00 p.m., R6 stated if NA-P was working on her hall and she had a request or need, she would wait until the next shift. During a subsequent interview on 9/12/25 at 12:30 p.m. , R6 stated NA-P would say totally inappropriate things and then laugh trying to make up for whatever NA-P had said, increasing R6's frustration. R6 further described NA-P as being loud and obnoxious. R65 stated she had reported NA-P but to management, but nothing ever gets done. R7's social services MDS data collection tool dated 7/17/25, identified moderately impaired cognition, and had no behaviors or rejection of cares.R7's face sheet dated 9/12/25, indicated diagnoses of chronic obstructive pulmonary disease (COPD), generalized anxiety, and rheumatoid arthritis.During an interview on 9/11/25 at 2:27 p.m., R7 did not know staff names, however, gave a detailed description was consistent with NA-P. R7 stated NA-P was rough with cares and this upset her but what was she to do, she needed two staff for cares. R7 further stated during a subsequent interview on 9/12/25 at 12:35 p.m., stated she did not want NA-P to come back to work with her and just described her cares as rough.During an interview on 9/11/25 at 1:03 p.m., NA-G stated she had witnessed NA-P on different dates talking back to R1. NA-P seemed to enjoy upsetting R1 and other resident to see if NA-P could get a reaction from them. NA-G had reported this to the DON. NA-G had not noticed a change with NA-P's behavior with residents.During an interview on 9/11/25 at 3:32 p.m., assistant director of nursing (ADON)-A described NA-P demure as lacking a bed side manner but was meeting the needs of the residents appropriately. Further stated NA-P had not had any rough cares. When the NA-P's written warning was brought up ADON-A would not count rushed and harsh as rough cares.During an interview on 9/12/25 at 7:40 a.m., DON stated she had gone over the grievance form with NA-P on 9/5/25, and asked NA-P slowed down and encouraged NA-P to treat residents as individuals and had individual care needs and to provide quality care to all residents.Review of NA-P employee files included:-a coaching/teachable moment dated 7/18/25, for her tone of voice and disrespectful and condescending to coworkers.- a written warning dated 8/1/25, NA-P being harsh and rushed, staff have complained about tone and verbiage coming from NA-P that was demeaning and lacked appropriate bedside manner.- a grievance 9/5/25, DON wrote for R1, where R1 identified NA-P by name and reported NA-P was too fast during cares and that it was possible would not like NA-P to assist with cares if possible. Review of facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7/8/24 indicated the following: -Personal degradation of a dependent adult, means a will act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person.-Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report an allegation of abuse timely to the State Agency for 1 of 1 resident (R1) who reported staff to resident physical abuse. Findings include:A facility five-day investigation submitted by the administrator to the State Agency on9/3/25 indicated on 8/28/25, R1 had clinic appointment and had become upset with the physician. The report included a statement R1 made to the physician then we should talk about Glen Oaks and the staff that is beating me up. In review of facility reported incidents to the State Agency there was no indication R1's allegations of abuse were reported to the State Agency. R1's significant Minimum Data Set (MDS) dated [DATE], indicated R1 did not have cognitive impairment. R1 had verbal behaviors and rejection of cares.During an interview on 9/11/25, at 10:17 a.m., Administrator confirmed she submitted the five-day report to the State Agency that included the allegation of abuse R1 had made. On 8/28/25, she was told by the facility scheduler (SCH)-A who heard R1 make the allegation to the physician during her appointment on 8/28/25. The Administrator indicated when she had talked with R1 she was not able to provide specific details of the incident including who the staff member involved and was not willing to further discuss the incident and therefor did not consider the incident reportable.During an interview on 9/12/25 at 7:40 a.m., director of nursing (DON) stated was made aware of incident on 9/5/25 when R1 made a grievance towards NA-P. DON filled out the grievance form and talked with NA-P. DON did not make a report to the SA, regarding the allegation of rough cares as she did not consider rough cares as a reportable event. Review of facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 7/8/24 indicated the following:Reporting:-All allegation of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation of property should be reported immediately to the administrator.-All allegations of resident abuse shall be reported to the appropriate state entity not later than two hours after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a thorough investigation was completed and protect residents after 2 of 2 allegations which included rushed and harsh cares in addition to physical abuse were reported by unknown residents which effected (R1, R4, R6, and R7) who reported on going inappropriate behavior and treatment by nursing assistant (NA)-P. Findings include:Review of NA-P's employee record included a written warning dated 8/1/25, that was authored by assistant director of nursing (ADON)-A. The ADON wrote- residents complained of nursing assistant (NA)-P being harsh and rushed, staff have complained about tone and verbiage coming from NA-P that is demeaning and lacked appropriate bedside manner. NA-P's employee record nor did the disciplinary action document identify which residents were involved that led to NA-P's written warning. Further, there were no recorded grievances and/or documentation of the concerns voiced by residents, there was no indication of an investigation into the concerns, or evident that follow-up with the effected residents was completed. During an interview on 9/11/25 at 3:32 a.m. ADON-A described NA-P's demeanor as lacking a bed side manner but was meeting the needs of the residents. ADON reviewed the written warning and explained she would not consider the description of rushed and harsh as rough cares, however, did not investigate the allegations because she did not think NA-P's rushed and harsh demeanor would be considered abuse. R1's significant Minimum Data Set (MDS) dated [DATE], R1 did not have cognitive impairment. R1 had history of falls, and diagnoses of fractured hip, chronic obstructive pulmonary disease (COPD), dependent on oxygen and dependent on staff to perform activities of daily living (ADLs) and used a wheelchair. R1 had verbal behaviors and rejection of cares.R1's 7/7/25 did not identify R1's vulnerabilities to abuse, was dependent on staff for activities of daily living involving transfers and toileting and had the risk for or had the potential of altered mood and behaviors. During an interview on 9/11/25 at 11:37 a.m., R1 stated she was very familiar with NA-P. R1 explained NA-P was very rough during cares. When NA-P rolled her in bed she would push really hard on her broken hip and move too fast which caused her increased pain. When R1 would tell NA-P she was hurting her by the way she was moving her, it seemed like NA-P would just push harder. R1 stated when she thinks about NA-P and when NA-P helps her with cares, her anxiety increased and caused her to act out. R1 had reported to ADON-A how NA-P treats her however, nothing changed. During a subsequent interview on 9/11/25 at 2:07 p.m., R1 stated the way NA-P treats her made her feel worthless and would prefer NA-P not come into her room.During an interview on 9/10/25 at 1:40 p.m., scheduler (SCH)-A stated she was with R1 at the clinic appointment on 8/28/25 when R1 made an accusation about staff was abusing her, by throwing R1 around. R1 did not tell SCH-A who that staff person was. When SCH-A got back to the facility she reported R1's allegations to the administrator.A facility five-day investigation of R1's fall from a wheelchair van lift submitted by the administrator to the State Agency (SA) on 9/3/25 indicated on 8/28/25, R1 had clinic appointment and had become upset with the physician. The report included a statement R1 made to the physician then we should talk about Glen Oaks and the staff that is beating me up. In review of investigatory file and facility reported incidents to the State Agency there was no indication any allegations of abuse were investigated after R1 made her statement.A handwritten grievance dated 9/5/25, authored by the director of nursing (DON) on behalf of R1 indicated NA-P was too fast during cares and did not want NA-P to assist her if possible. Facility records did not include any documentation of investigation activities such as interviewing other residents or staff members.During an interview on 9/11/25, at 10:17 a.m., Administrator confirmed she submitted the five-day report to the State Agency that included the allegation of abuse R1 had made. On 8/28/25, she was told by the facility scheduler (SCH)-A who heard R1 make the allegation to the physician during her appointment on 8/28/25. The Administrator indicated when she had talked with R1 she was not able to provide specific details of the incident including who the staff member involved and was not willing to further discuss the incident and therefor did not consider the incident reportable. Furthermore, Administer denied knowledge of NA-P's written warning 8/1/25, or grievance of 9/5/25.During an interview on 9/12/25 at 7:40 a.m., director of nursing (DON) stated she was made aware of incident on 9/5/25, while she was talking with R1. R1 stated NA-P was too fast with cares and asked DON to file a grievance against NA-P. DON filled out the grievance form and talked with NA-P on 9/5/25. DON did not complete an investigation and not talk to other residents about the care NA-P provided. However, DON provided education to NA-P to slow down during cares, every resident has different needs, and residents deserved quality of care. R4's social services

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to follow manufacturer's safety guidelines for operating a wheelchair lift for 1 of 1 resident (R1). The facilities failures resulted in actual harm when R1 fell to the ground and sustained a head laceration that required transfer to the hospital emergency department for treatment. Findings include:Facility reported incident (FRI) #361588 submitted on 8/28/25, identified on 8/28/25, R1 experienced a fall from the facility transport bus while being transferred via the wheelchair lift. The incident occurred at approximately 11:30 a.m. during a scheduled clinic visit. R1 was being loaded onto the bus by trained staff (scheduler (SCH)-A).R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 did not have cognitive impairment, had diagnoses of fractured hip, chronic obstructive pulmonary disease (COPD), R1 was dependent on staff for activities of daily living (ADLs), had a history of falls, and used oxygen. R1 had verbal behaviors and rejected cares. R1 was dependent on staff for self-care and indoor mobility, used manual wheelchair, and had impairment on one lower extremity.R1's mobility and transfer care plan dated 7/9/25, indicated R1 had a self-care deficit as evidenced by R1 requiring assistance with ADLs, impaired balance during transfers and/or walking. The following interventions were included:-R1 used a wheelchair and required staff to propel it-R1 requires assist of 1 with bed mobility-R1 required assist of two staff for toileting-R1 requires assist of two staff for transfersR1's mood and behavior care plans dated 7/9/25, did not identify target behaviors that R1 had displayed and/or had a history of. The care plan included focus for behavior which identified alteration and at risk for negative statements, repetitive questions, verbalizations, persistent anger with staff or others, self-depreciation, expressions of unrealistic fears, sadness, crying, repetitive movements, withdrawn/reduced socialization related to diagnoses of depression. The care plan also had the focus of R1 had a potential for psycho-social well-being deficit and is at risk for changes in appetite, sleep patterns, ADL's, mood, socialization and increased sensitivity to environment, An additional focus included R1 had the potential for episodes of alteration in mood as evidenced by restlessness, easily fatigued, being irritable, having headaches/stomachaches, excessive worrying or difficulty controlling feelings of worry and having trouble falling asleep and/or staying asleep related to diagnosis of anxiety. R1's progress note dated 8/28/25 at 3:33 p.m., indicated R1 went to the emergency department after a fall while be loaded into the facility bus. R1 returned to Glen Oaks with no changes to medications.R1's progress note dated 8/29/25 at 8:31 p.m., described the fall incident that occurred on 8/28/25 at 11:20 a.m. The note identified, R1 was taken to a doctor appointment by staff trained to operate the facility bus and passed driver assessment. They arrived at clinic at 10:25 a.m. and were taken to exam room. Medical doctor (MD)-A and R1 had a heated discussion over her antianxiety and opioid medications. MD-A ended the appointment with the mention of R1 returning to hospice to help manager her anxiety and pain. SCH-A took R1 to the bus and was loading R1 backwards onto the ramp, locked the brakes, was standing on the ramp and holding R1's wheelchair while raising the ramp. Ramp stopped moving about six inches from the ground. SCH-A was looking for what stopped the ramp and stepped off ramp. SCH-A first checked right brake to make sure was on. SCH-A stepped off the ramp and R1 fell forward off her wheelchair hitting her head on the ground first. Staff went to get help, then attended to R1's bleeding head. Front wheels of wheelchair were off the yellow foot stop by three inches, brakes on all the way both sides. R1 obtained a four-centimeter laceration to right forehead as well as a hematoma directly right of eye in temporal area. R1 reported throbbing pain to head and denied pain anywhere else.R1's Medical and Transport/Emergency Documentation Form dated 8/28/25, that was handwritten included, 11:20 fell in parking lot out of w/c [wheelchair] to pavement. Right forehead laceration. R1's hospital emergency department after visit summary (AVS) dated 8/28/25 identified R1 was evaluated for a fall with injury; laceration to forehead. The AVS identified R1 had stiches that were to come out in 10-14 days with directions for wound care. There was no other information on the summary pertaining to the fall and/or R1's head injury. The facility investigation dated 8/28/25, included the aforementioned information pertaining to the fall. The form Skilled Nursing Facility-Fall investigation Form identified the time of the fall as 11:20 a.m. R1 was wearing slippers and also sustained a right shoulder abrasion in addition to the forehead laceration that was bleeding. R1's baseline behavior of the day was anxious. This document also included a handwritten statement by scheduler (SCH)-A. The statement included SCH-A had wheeled R1 backwards onto the ramp, locked the breaks, was standing on the ramp with R1 holding onto the wheelchair and the remote, started to raise the ramp. The

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to ensure performance evaluations for 4 of 4 nursing assistants (NA-P, NA-D, NA-S, and NA-L) were provided within the past 12 months.Findings include:Review of nursing assistant (NA)-P employee record identified a hire date of 10/25/23 and did not include a performance evaluation since NA-P's hire date. During interview on 9/12/25, nursing assistant (NA)-P could not remember receiving a performance evaluation since she was hired. Review of (NA)-D's employee record identified a hire date of 11/10/22 and included a performance evaluation dated 3/13/23; there were no subsequent performance evaluations included in her record.Review of NA-S employee record identified a hire date of 4/15/22 and included a performance review dated 3/13/23; there were no subsequent performance evaluations included her the record. During interview on 9/12/25 at 8:27 a.m., NA-S could not remember receiving a performance evaluation since 2023. Review of NA-L's employee file identified a hire date of 2/18/20, a performance evaluation for 2022 was found but no other performance evaluation were located in her file.During an interview on 9/12/25 at 7:40 a.m., director of nursing (DON) indicated she had not done any performance evaluations for nursing assistants in her three years as DON at the facility.During an interview on 9/12/25 at 12:30 p.m., Administrator indicated there was no policy for annual evaluations of nursing assistants but was an expectation they were completed.