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	06/10/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to maintain an effective infection prevention and control surveillance program to identify, track, and analyze potential infections, including signs and symptoms of infections that did not result in antibiotic treatment, which had the potential to affect all 40 residents who resided in the facility. In addition, the facility failed to ensure appropriate personal protective equipment (PPE) was properly utilized during care for 1 of 1 resident (R2) reviewed for enhanced barrier precautions (EBP). Findings include: The facility's infection surveillance tracking logs from 3/1/26 through 5/31/26, identified the facility had tracked infections when a resident received antibiotic treatment. However, the surveillance logs failed to include monitoring and tracking of resident signs and symptoms of potential infections, including infections or communicable illnesses that had not resulted in antibiotic use. The facility's infection surveillance system failed to ensure all suspected infections were identified, monitored, analyzed, and trended to assist with prevention, investigation, and control of infections within the facility. During an interview on 6/10/26 at 1:01 p.m., Infection Preventionist (IP)-A confirmed the facility had only tracked infections related to antibiotic use. IP-A stated the facility treated resident signs and symptoms of potential infections as they occurred, and symptoms were not documented on the infection surveillance tracking logs unless antibiotic treatment was initiated. IP-A stated concerns such as diarrhea were discussed during morning meetings, including whether other residents had similar symptoms, but the facility did not have a tracking process in place for those symptoms. During an interview on 6/10/26 at 1:37 p.m., Director of Nursing (DON)-A stated the expectation was the facility's infection prevention and control program included monitoring and tracking of all suspected and confirmed infections to identify trends and implement interventions to prevent the spread of infections. R2's quarterly Minimum Data Set (MDS), dated [DATE], indicated R2 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), and diagnoses included gastrostomy status (artificial opening created directly into the stomach, typically for a feeding tube), acid reflux, quadriplegia, epilepsy and anemia. R2's care plan, revised 4/9/24, indicated R2 required EPB related to presence of an indwelling medical device, and staff would adhere to the use of EBP during completion of high-contact activities. During observation on 06/09/2026 at 5:20 p.m., a sign posted on R2's room door notified of EBP and (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	directed staff to wear gown and gloves for feeding tube and wound care. During observation on 6/9/26 at 5:25 p.m., LPN-A entered R2's room, obtained water from the bathroom, and applied gloves. LPN-A left the room twice to obtain supplies, applied gloves, and administered R2's medications through the feeding tube. LPN-A then completed hand hygiene, applied new gloves, and completed wound care at feeding tube site. However, LPN-A failed to were a gown while feeding tube activities and wound care was completed. During interview on 6/9/26 at 5:43 p.m., LPN-A stated R2 was on EBP and gown and gloves should have been worn before the medications were administered and wound care was provided to reduce the spread of infection. LPN-A stated she was aware R2 was on EBP and EBP signs were on the door. During interview on 6/10/26 at 1:10 p.m., infection preventionist (IP) stated when a resident was placed on EBP, signs were placed on the door, bins with personal protective equipment (PPE) were placed by the door, and the information was indicated on the resident's care plan. IP stated staff were expected to wear gown and gloves with any high-contact care including dressing, bathing, grooming, feeding tube medication administration and feeding tube cares, to protect the staff and other residents from the spread of infection around the facility. IP stated agency staff received education before their first shift on facility EBP expectations. During interview on 6/10/26 at 2:27 p.m., director of nursing (DON) stated if there was EBP signage and bins outside of the room and the staff were going to touch the resident, staff were expected wear a gown and gloves. DON stated EBP compliance was important to reduce the chance of spreading infection and not putting residents and staff at risk. The facility's Infection Surveillance policy, dated 1/1/26, identified infection surveillance was an ongoing systematic collection, analysis, interpretation, and sharing of infection-related data. The policy identified the purpose of surveillance was to identify infections, monitor infection prevention practices, reduce infections, and prevent the spread of infections. The policy identified nursing staff participated in surveillance by assessing residents and reporting changes in condition, including when residents developed signs and symptoms of infection. The policy further identified the facility would collect data related to possible infections, including infection site, signs and symptoms, trends, patterns, and documentation of resident and staff reported signs and symptoms. The policy indicated all resident infections were to be tracked. The facility's Infection Prevention and Control Program policy, dated 1/1/26, identified the facility maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections. The policy identified a surveillance system was utilized for prevention, identification, reporting, investigation, and control of infections and communicable diseases. The policy further identified the IP was responsible for surveillance activities, maintaining documentation of findings and corrective actions, and reporting surveillance findings to the Quality Assessment and Assurance Committee. The policy identified licensed nurses participated in surveillance through assessment of residents and reporting changes in condition. The facility's Enhanced Barrier Precautions policy, dated 2025, indicated PPE for EBP is only necessary when performing high-contact care activities which included wound care and device care or use of feeding tubes.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications were managed appropriately, including failure to complete monitoring for potential adverse effects related to antipsychotic medication use, and failure to ensure a PRN (as needed) psychotropic medication order included a required stop date/duration, for 2 of 5 residents (R6 and R26) reviewed for unnecessary medications.Findings include:R6's annual Minimum Data Set (MDS), dated [DATE], identified R6 had moderate cognitive impairment, received antipsychotic medication, and diagnoses included anxiety disorder, bipolar disorder (a mental health condition that caused changes in mood, energy, and activity levels), schizophrenia (a mental health condition that affected a person's thoughts, emotions, and behaviors), and obsessive-compulsive disorder. R6's physician orders, dated 6/10/26, identified an order for risperidone (an antipsychotic) 2 milligrams (mg) by mouth two times a day for schizotypal disorder related to schizophrenia, initiated 3/3/26. R6's physician orders further identified an order for monthly orthostatic blood pressure (to monitor for drop in blood pressure with position changes) while receiving antipsychotic medications, initiated 3/25/26. R6's electronic health record (EHR) from January 2026 through June 2026 identified orthostatic blood pressure monitoring was completed for April 2026. However, the EHR lacked documentation staff completed required monthly orthostatic blood pressure assessments for January, February, March, May and June 2026.R26's significant change MDS, dated [DATE], identified R26 had moderate cognitive impairment, and diagnoses included bipolar II disorder (a mental health condition that caused changes in mood and episodes of depression and elevated mood), anxiety disorder, and hallucinations (seeing or hearing things that were not present).R26's physician orders, dated 6/10/26, identified an order for lorazepam (an anti-anxiety psychotropic medication) 0.5 mg by mouth every four hours PRN for anxiety, initiated 5/14/26. However, R26's PRN lorazepam order did not include a stop date, specific duration, or documented prescriber rationale for extending the PRN psychotropic medication beyond 14 days, as required.During an interview on 6/10/26 at 10:05 a.m., registered nurse (RN)-C reviewed R26's order in the EHR and confirmed the lorazepam order did have an ordered end date.During an interview on 6/10/26 at 11:27 a.m., assistant director of nursing (ADON) stated staff attempted other coping mechanisms prior to administering a PRN medication. However, when interventions were ineffective, staff administered the PRN medication. ADON confirmed R26's PRN lorazepam order was initiated on 5/14/26 and did not have a specified stop date. ADON stated PRN psychotropic medications required a 14-day stop date unless the provider documented rationale for continued use beyond 14 days. ADON stated the PRN lorazepam order should have included an end date.During an interview on 6/10/26 at 12:21 p.m., ADON reviewed R6's clinical record and confirmed the orthostatic blood pressure monitoring was only completed in April 2026 and the remaining five monthly assessments from January 2026 through June 2026 were missing. ADON stated the orthostatic blood pressure monitoring was related to the resident's psychotropic medication use and was used to monitor for adverse effects.During an interview on 6/10/26 at 12:40 p.m., director of nursing (DON) stated PRN psychotropic medications required a 14-day end date and, if the medication continued to be needed, the provider should have been contacted for a new order or rationale for continued use. DON stated this was important to ensure the medication continued to be necessary and to discontinue medications residents no longer needed. Additionally, DON stated orthostatic blood pressure monitoring was placed on the medication administration record (MAR) and the shift nurse was responsible for completing the monitoring. DON stated if the monitoring was not completed, it should have been communicated during report. DON stated orthostatic blood pressure monitoring was important because changes in blood pressure could cause the resident to become more unstable on their feet, which increased the risk for falls and other concerns.The facility's Use of Psychotropic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication(s) policy, dated 2026, indicated psychotropic medications included antipsychotic and anti-anxiety medications. Residents receiving psychotropic medications were to be monitored for effectiveness and adverse effects, and the resident's response to the medication was to be documented in the medical record. Additionally, PRN psychotropic medications, excluding antipsychotics, were limited to 14 days unless the provider documented a rationale for continued use beyond 14 days and included a specific duration.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information regarding bed hold and return rights when a resident was transferred to the hospital for 1 of 1 resident (R6) reviewed for hospitalization.Findings include:R6's annual Minimum Data Set (MDS), dated [DATE], identified R6 had moderate cognitive impairment and diagnoses included mild cognitive impairment, schizophrenia (a chronic mental health disorder affecting thoughts, perceptions, and behavior), bipolar disorder (a mood disorder characterized by episodes of depression and mania), and seizure disorder/epilepsy.R6's progress note, dated 12/5/25 at 5:55 a.m., indicated R6 was transferred to the hospital on [DATE] after being found on the floor experiencing active seizure activity with convulsions and unresponsiveness. However, R6's EHR lacked evidence the facility provided R6 and/or R6's resident representative with a written bed hold notice at the time of transfer to the hospital. During an interview on 6/09/26 at 2:50 p.m., Social Service Designee (SSD) stated nursing staff completed bed hold paperwork when residents were transferred to the hospital.During an interview on 6/10/26 at 10:05 a.m., registered nurse (RN)-C stated when a resident was sent to the hospital, the nurse obtained a verbal bed hold from the resident if they were able to provide one. If the resident was unable, the nurse contacted the resident's representative by telephone and obtained the information. RN-C stated the bed hold information was documented in the progress notes. During an interview on 6/10/26 at 11:27 a.m., Assistant Director of Nursing (ADON) stated the nurse on duty was responsible for asking about the bed hold. ADON stated a paper form was completed and, if needed, uploaded into the resident's electronic record.During an interview on 6/10/26 at 12:21 p.m., ADON confirmed R6's clinical record lacked bed hold documentation for R6's 12/5/25 hospitalization.During an interview on 6/10/26 at 12:40 p.m., Director of Nursing (DON) stated when a resident was transferred to the emergency room, nurses were expected to complete paperwork regarding the bed hold. DON stated if the resident was unable to complete the information, the resident representative should have been contacted to obtain verbal confirmation. DON stated the form included the date the resident was transferred and the hospital location. DON further stated completion of the bed hold process was important for billing, insurance, held the resident's placement, and ensured the correct disposition was documented.The facility's Bed Hold Notice policy, dated/revised 2025, identified the facility would provide written information to the resident and/or resident representative regarding bed hold practices both in advance and at the time of transfer for hospitalization or therapeutic leave. The policy identified the written information would include the duration of the state bed hold policy, reserve bed payment information, facility bed hold policies, and conditions related to the resident's return to the facility. The policy further identified that during an emergency transfer, the facility would provide written notice of bed hold policies to the resident and/or resident representative within 24 hours and would maintain a signed and dated copy of the bed hold notice in the resident's file and/or medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included individualized interventions for the use of a seat belt while seated in a wheelchair for 1 of 1 resident (R4) reviewed for comprehensive care plans.Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R4's diagnoses included dementia, paraplegia (loss of movement and function in the lower body), and dysarthria and anarthria (difficulty or inability to speak clearly due to problems with muscle control). The MDS further identified R4 received antipsychotic and antidepressant medications, used a trunk restraint daily, and had no impairment of the upper extremities.During an observation on 6/8/26 at 1:15 p.m., R4 was observed seated in his wheelchair with a seat belt (trunk restraint) secured over R4's lap.R4's comprehensive care plan, dated 4/9/26, failed to identify the use of a wheelchair seat belt and individualized interventions related to the seat belt use, including the purpose of the device, level of required staff assistance, monitoring, safety considerations, and resident-specific needs related to the interventions.During an interview on 6/10/26 at 9:27 a.m., nursing assistant (NA)-A stated R4's seat belt was not indicated on the NA care sheet that direct R4's cares. NA-A stated staff attempted to apply R4's seat belt in the morning and R4 frequently refused use of the seat belt. NA-A further stated the seat belt should have been included on R4's care plan.During an interview on 6/10/26 at 9:54 a.m., NA-B stated R4 utilized a seat belt when seated in his wheelchair. NA-B stated staff attempted to apply the seat belt, and R4 frequently refused and yelled at staff. During an interview on 6/10/26 at 12:21 p.m., assistant director of nursing (ADON)-A stated the seat belt was assessed with a change in condition. ADON-A confirmed the seat belt was not identified in R4's care plan. ADON-A stated the seat belt should have been included on R4's care plan.During an interview on 6/10/26 at 12:40 p.m., director of nursing (DON)-A stated the seat belt should have been included in R4's care plan because the care plan directed staff on how to provide care for the resident.The facility's Comprehensive Care Plans policy, dated/revised 2025, identified the facility developed and implemented a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs. The policy indicated the comprehensive care plan included all services identified in the resident's comprehensive assessment and services met professional standards of quality, and the care plan included resident-specific interventions that reflected the resident's needs and preferences.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident care plans were revised for 1 of 1 resident (R28) reviewed for elopement. Findings include: R28's admission Record, dated 6/10/26, indicated diagnoses of Alzheimer's disease, major depression, anxiety disorder, hallucinations and muscle weakness. R28's quarterly Minimum Data Set (MDS), dated [DATE], indicated R28 was severely cognitively impaired, received substantial/maximal assistance assist with eating, and was dependent with all other activities of daily living (ADLs). R28 resided on the secured memory care unit and a keypad code was required to enter and exit the secured unit. During multiple observations on 6/8/26 through 6/10/26, when R28 was not in her room recliner watching TV or sleeping, R28 was propelled by staff to and from her room to dining room and to activities off the secured memory unit in the main dayroom of the facility. R28's last Elopement Risk Assessment, dated 11/10/25, R28 scored a 3, indicating a low risk for elopement. The assessment indicated a score of 5 or more is considered to be at risk for elopement. R28's care plan, revised 8/23/23, indicated R28 was at high risk for elopement with a score of 10 and wandered with no rational purpose and attempting to open doors. However, R28 was observed dependent with all transfers, mobility, cares, meals and activities. During an interview on 6/09/26 at 2:15 p.m., trained medication assistant (TMA)-A stated R28 was totally dependent on staff for all her cares but does feed self when food cut into finger foods. TMA-A stated she had not seen resident attempting to exit the unit, nor would be able to reach the keypads from her wheelchair. During an interview on 6/10/26 at 11:24 a.m., registered nurse (RN-A) and social service designee (SSD) stated resident was no longer actively exit seeking. SSD stated she had observed resident fiddling with doorknob going out to the enclosed courtyard but had not been able to open it. RN-A stated it had been a long time since R28 had been an elopement risk. During an interview on 6/10/26 at 11:33 a.m., the director of nursing (DON) stated the facility's expectation for care plan revision would be any changes noted during an assessment (quarterly/annual/significant change) or in review at a resident's care conference. The corporate nurse agreed R28 was no longer an elopement risk.The facility's Comprehensive Care Plan policy, dated 2025, indicated the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure a restorative device was implemented and monitored to maintain a resident's highest practicable level of function when staff failed to ensure a right hand splint used for contracture management had a current order, and failed to document application attempts or refusals of the splint for 1 of 3 residents (R4) reviewed for range of motion.Findings include:R4's quarterly Minimum Data Set (MDS), dated [DATE], identified R4 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R4's diagnoses included arthritis, paraplegia (loss of movement and/or sensation in the lower part of the body), and dysarthria and anarthria (conditions that affected a person's ability to speak clearly). On 6/8/26 at 11:28 a.m., R4 was observed with his right hand completely contracted with his thumb positioned inside his curled hand. R4 stated he thought he had a splint or something to put in his hand but was unsure.R4's care plan, dated 4/9/26, identified R4 had a self-care deficit related to requiring assistance with ADLs and impaired mobility. The care plan directed staff to apply R4's right hand splint as ordered and as R4 allowed, use a rolled washcloth if the splint was unavailable, check skin integrity with application and removal, and notify the primary care provider (PCP) of any abnormalities.Nursing assistant care sheet, undated, identified R4 required a hand splint to the right hand. R4's electronic health record (EHR) identified a splint order had been discontinued in February 2026. However, R4's EHR lacked a current physician order for the right hand splint. Additionally, the EHR lacked instructions identifying when the splint was to be applied, the length of time the splint was to be worn, removal instructions, and monitoring requirements. The EHR further lacked documentation to determine if staff attempted to apply the splint, used the care-planned alternative intervention of a rolled washcloth, monitored skin integrity, or if R4 refused the intervention.During an interview on 6/10/26 at 9:27 a.m., nursing assistant (NA)-A confirmed R4's right hand splint was listed on the nursing assistant care sheet. NA-A stated staff attempted to apply the splint in the mornings and R4 would frequently refuse.During an interview on 6/10/26 at 9:54 a.m., NA-B stated staff attempted to apply R4's splint, and R4 would frequently yell at staff and refuse application.During an interview on 6/10/26 at 11:27 a.m., the assistant director of nursing (ADON) stated R4 had a splint in his room and frequently refused the splint when staff attempted application. The ADON reviewed R4's medical record and confirmed there was no current order for the splint and no documentation to show staff attempted to apply the splint or that R4 refused the splint. The ADON stated the splint order had been discontinued in error in February 2026 and should have remained active.During an interview on 6/10/26 at 12:40 p.m., the Director of Nursing (DON) stated when a resident was evaluated by therapy and a splint was recommended, the recommendation should have been processed as an order. The DON stated the splint order should have been placed on the medication administration record (MAR) for staff to document application of the splint or resident refusal. The DON further stated residents were screened quarterly and with a change in condition to determine continued need for the splint and to identify any decline in function.The facility's Use of Assistive Devices policy, undated, indicated assistive devices were provided to residents requiring equipment to maintain or improve function and quality of life. The policy indicated assistive devices would be based on the resident's assessment and plan of care. The policy further indicated staff would monitor for consistent use of the device, and refusals or problems with the device would be documented in the medical record.The facility's Prevention of Decline in Range of Motion policy, undated, indicated the facility would provide interventions and/or therapy to maintain or improve range of motion, including appropriate equipment such as braces or splints. The policy indicated care plan interventions would include the type of treatment, frequency and duration of treatments, and resident goals. The policy further indicated the nurse responsible for the resident would monitor for (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consistent implementation of interventions, and refusals or problems associated with range of motion interventions would be documented in the medical record.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure dialysis-related care needs were coordinated and implemented, including failure to clarify and implement fluid restriction interventions, for a resident at risk for fluid overload for 1 of 1 resident (R11) reviewed for dialysis services.Findings included:R11's quarterly Minimum Data Set (MDS), dated [DATE], identified R11 had intact cognition, required assistance with activities of daily living (ADLs), and received dialysis services. R11's diagnoses included hypertension (high blood pressure), peripheral vascular disease (PVD; a condition causing decreased blood flow through the blood vessels), renal insufficiency (reduced kidney function), diabetes mellitus, schizophrenia (a mental health disorder affecting thoughts, emotions, and behaviors), and polyneuropathy (damage to multiple nerves causing weakness, numbness, or pain). R11's care plan, initiated 1/29/26, identified R11 had a diagnosis of end stage renal disease (permanent kidney failure requiring dialysis or transplant), received dialysis, and was at risk for fluid overload, and interventions directed staff to monitor for signs and symptoms of hypovolemia (low fluid volume) and hypervolemia (excess fluid volume). The care plan further directed staff to monitor, document, and report edema, unexplained weight gain, neck vein distention, difficulty breathing, increased heart rate, elevated blood pressure, changes in level of consciousness, and abnormal breath sounds. Additional interventions included obtaining lab reports, completing before and after dialysis assessments per dialysis protocol, and obtaining weights per facility protocol. However, the care plan failed to identify the amount of fluid R11 was allowed to receive daily and to direct staff to monitor fluid intake.R11's electronic health record (EHR) identified R11 received dialysis services. However, the EHR failed to identify a physician order or dialysis recommendation specifying the amount of fluid R11 was allowed to receive daily. Additionally, the EHR failed to identify documentation the facility communicated with the dialysis provider to clarify R11's fluid restriction recommendations, obtain necessary orders, and implement interventions to guide staff in monitoring fluid intake. On 6/9/26 at 11:50 a.m., R11 entered the dining room in his wheelchair. R11 was provided a cup of coffee and a glass of ice water. R11 then requested a large pitcher of water from the dining aide.On 6/9/26 at 12:09 p.m., R11 was observed in his room with three water pitchers on his bedside table, along with a bottle of water and a plastic cup that was half full of water.On 6/10/26 at 9:08 a.m., R11 was observed with one water pitcher, two plastic cups, and a bottle of water on his bedside table. R11 stated he was supposed to limit his water intake but did not know how much fluid he was allowed.During an interview on 6/9/26 at 5:45 p.m., nursing assistant (NA)-C stated R11 was on a renal diet but did not have any restrictions regarding fluids. NA-C reviewed R11's care sheet and stated it did not identify a fluid restriction.During an interview on 6/10/26 at 8:10 a.m., Fresenius Kidney Care registered nurse (RN)-D stated R11 should have been on fluid restrictions, as most residents receiving dialysis required fluid restrictions. RN-D stated R11's fluid restriction was 1800 milliliters (mL) daily. During an interview on 6/10/26 at 9:27 a.m., NA-A stated R11 was not on a fluid restriction. NA-A reviewed R11's care sheet and stated it identified a dialysis diet but did not include a fluid restriction. NA-A stated if a resident had a fluid restriction, it would have been listed on the care sheet and provided an example of another resident whose fluid restriction was listed.During an interview on 6/10/26 at 9:54 a.m., NA-B stated fluid restrictions were listed on the care sheet. NA-B reviewed R11's care sheet and stated R11 was not identified as having a fluid restriction.During an interview on 6/10/26 at 9:57 a.m., trained medication aide (TMA)-B stated fluid restrictions were listed on the resident medication administration record (MAR) orders. TMA-B reviewed R11's MAR and stated it did not indicate R11 was on a fluid restriction.During an interview on 6/10/26 at 11:27 a.m., assistant director of nursing (ADON) stated dialysis residents were monitored using a dialysis communication sheet completed prior to appointments. The ADON stated R11 was on a fluid restriction. After reviewing R11's record, the ADON stated fluid restrictions were usually listed under (continued on next page)

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	245360	A. Building B. Wing	06/10/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the diet order but stated, I am not seeing it typed in for him. I don't see an active fluid restriction in place for him. The ADON stated fluid restrictions were important because excess fluids could be disruptive to the dialysis process and impact the resident's blood and medications.During an interview on 6/10/26 at 12:37 p.m., the director of nursing (DON) stated not all dialysis residents were on fluid restrictions and restrictions depended on provider orders. The DON stated staff were expected to educate residents regarding risks and benefits, update dialysis and the physician as needed, and communicate with dialysis regarding fluid restriction orders. The DON stated communication and formal conversations regarding dialysis-related needs should have been documented. The facility's Fluid Restriction policy, undated, identified fluid restrictions would be followed according to physician orders. The policy identified fluid restrictions may be needed for residents with medical conditions including end stage renal disease (ESRD). The policy directed nurses to obtain and verify physician orders for fluid restrictions, including the amount of fluid allowed in a 24-hour period. The policy further directed staff to communicate fluid restrictions to appropriate departments, document the restriction according to facility protocol, and ensure bedside water was included in the resident's daily fluid allowance.

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure specialized rehabilitative services were provided as ordered when the facility failed to ensure a physician's order for occupational therapy (OT) evaluation and treatment was completed timely for 1 of 1 resident (R4) reviewed for specialized rehabilitative services.Findings include:R4's quarterly Minimum Data Set (MDS), dated [DATE], identified R4 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included arthritis, paraplegia (loss of movement and/or sensation in the lower part of the body), dorsalgia (back pain), aphasia (difficulty understanding or expressing speech), and dysarthria and anarthria (difficulty speaking due to impaired muscle control). The MDS further identified R4 had impairment on both sides of the lower extremities, and a trunk restraint was used daily.R4's progress note, dated 5/29/26 at 3:00 p.m., identified R4 was seen during provider rounds, and the provider was informed of R4's concerns related to decreased range of motion (ROM) in the right hand. The provider wrote an order for occupational therapy (OT) to evaluate and treat R4's right hand contracture (shortening or tightening of muscles, tendons, or other tissue that limits movement) and decreased ROM as indicated. The progress note identified therapy was informed and the order was entered into the electronic health record (EHR).R4's EHR identified the OT order was entered on 5/29/26. However, the EHR lacked evidence an OT evaluation was completed, services were initiated, or R4's right hand contracture and decreased ROM were assessed and addressed per the provider order.During an interview on 6/10/26 at 11:58 a.m., director of therapy (DTR) stated therapy completed quarterly screens for residents. DTR stated R4 was last seen by OT for positioning needs, which ended on 4/29/25, and R4 received a custom wheelchair. DTR stated R4 received physical therapy (PT) services beginning on 11/5/25 and was later discharged . DTR stated R4's most recent quarterly screen was completed on 5/26/26, and therapy did not identify significant changes at that time. DTR stated he was not aware of any new therapy orders after the last quarterly screen. DTR stated if therapy identified a change in condition, therapy would request orders for PT/OT services. DTR stated R4's quarterly screen, dated 5/26/26, had been considered R4's baseline.During an interview on 6/10/26 at 1:30 p.m., DTR stated he had not received the 5/29/26 OT order. DTR reviewed emails dated 5/29/26 and identified three unopened emails. DTR opened the emails and the OT order summary dated 5/29/26 was contained in one of the three previously unopened emails. During an interview on 6/10/26 at 11:27 a.m., assistant director of nursing (ADON) stated R4's right hand contracture had remained the same, R4's grip was tighter than normal, and the provider wrote orders for OT and PT assessments. ADON stated when a provider wrote an order, the nurse on duty was responsible for entering the order and placing it in a designated location at the nurses' station for a second check. ADON stated staff were expected to document a progress note to update the interdisciplinary team and discuss new orders during morning meetings. ADON provided facility morning meeting minutes dated 6/1/26 which identified therapy staff were present and aware of R4's new OT/PT orders.During an interview on 6/10/26 at 12:40 p.m., director of nursing (DON) stated orders were processed by the nurse on duty and scanned. DON stated some orders, including orders processed by agency nurses, were provided to nursing leadership for follow up. DON stated therapy orders were either scanned directly to therapy staff or provided as a hard copy.The facility's Consulting Physician/Practitioner Orders policy, undated, identified physician/practitioner orders were to be followed according to facility procedures. The policy directed nursing staff to process orders timely, including documenting the order, entering the order, and following facility procedures to ensure the order was carried out.The facility's Therapy Screen policy, undated, identified the Rehabilitation Department would perform therapy screens to identify needed services for residents. The policy directed therapists to complete screens for clinical referrals timely as determined by the facility and document the screen in the resident's medical record.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement an effective antibiotic stewardship program when the facility failed to complete antibiotic time-outs to evaluate the effectiveness and continued need for antibiotic therapy for 2 of 2 residents (R5 and R23) reviewed for antibiotic use.Findings include:R5's quarterly Minimum Data Set (MDS),dated 5/13/26, identified R5 had severe cognitive impairment and diagnoses included Alzheimer's disease.R5's physician orders, 5/14/26, identified an order for Macrobid (an antibiotic) Oral Capsule 100 milligrams (mg) by mouth two times a day for urinary tract infection (UTI) suspicion related to increased agitation for five days. The order was initiated on 5/15/26, and discontinued on 5/20/26.R5's electronic health record (EHR) lacked evidence the facility had completed an antibiotic time-out (reviewed R5's response to the antibiotic, monitored for improvement or worsening symptoms, reviewed available laboratory results, evaluated if the antibiotic remained appropriate, or determined if any changes to the treatment plan were needed).R23's comprehensive MDS, dated [DATE], identified R23 had severe cognitive impairment and diagnoses included renal (kidney) failure and diabetes mellitus.R23's physician orders, dated 5/29/26, identified the following antibiotic orders:Bactrim 400-80 mg by mouth twice daily, initiated on 3/28/26 and discontinued on 4/9/26.Amoxicillin 875 mg by mouth twice daily, initiated on 3/31/26 and discontinued on 4/5/26.Ciprofloxacin HCl 250 mg by mouth twice daily, initiated on 4/4/26 and discontinued on 4/13/26.Cephalexin 500 mg by mouth three times daily, initiated on 4/19/26 and discontinued on 4/27/26.Cipro 500 mg by mouth twice daily, initiated on 6/8/26 and discontinued on 6/13/26.R23's EHR lacked evidence the facility had completed antibiotic time-outs for the five separate antibiotic courses prescribed between 3/28/26 and 6/13/26, to ensure the antibiotics remained appropriate and effective.During an interview on 6/10/26 at 1:01 p.m., Infection Preventionist (IP) stated the facility utilized Loeb or McGeer criteria to determine if residents met criteria for antibiotic treatment. IP-A stated if a resident met criteria, information was sent to the provider for review. IP-A stated when a resident was started on an antibiotic, a 72-hour antibiotic time-out was expected to be completed and documented in the EHR. IP-A stated the antibiotic time-out included reviewing the resident's symptoms, response to treatment, and determining if the antibiotic remained appropriate. IP-A antibiotic time-outs had not been consistently completed as expected. IP-A stated she reviewed residents receiving antibiotics, entered their symptoms into the EHR, and faxed providers to request laboratory orders when indicated. IP-A stated antibiotic time-outs were important to ensure residents receive the correct antibiotic and to determine if a different antibiotic was more appropriate. IP-A reviewed R5 and R23's medical records and confirmed antibiotic time-outs were not completed.During an interview on 6/10/26 at 1:37 p.m., Director of Nursing (DON) stated the expectation was for resident signs and symptoms to be monitored and trended to identify concerns, patterns, or potential outbreaks. DON-A stated she expected antibiotic use be monitored, and appropriate antibiotic time-outs completed, tracked, and trended. DON-A stated antibiotic time-outs were important to protect residents from antibiotic overuse, unnecessary antibiotic treatment, and to ensure appropriate antibiotic stewardship.The facility's Antibiotic Stewardship Program policy, dated 1/1/26, identified the purpose of the program was to optimize the treatment of infections while reducing adverse events associated with antibiotic use. The policy identified nursing staff were to assess residents suspected to have infections, notify the physician, and utilize antibiotic protocols including McGeer criteria and Loeb Minimum Criteria. The policy identified the facility would monitor antibiotic use by monitoring residents' response to antibiotics and laboratory results when available to determine if the antibiotic continued to be indicated or if adjustments were needed. The policy further identified nursing staff were to monitor the initiation of antibiotics, monitor the resident's response to the antibiotic, review laboratory results, and consult with the practitioner to determine if the antibiotic should continue or if adjustments were needed based on findings.