STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Village Care Center	719 Southeast 2nd Street Glenwood, MN 56334

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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)

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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement immediate interventions to prevent re-occurrence following a fall from a full body (EZ Way) mechanical lift for 1 of 1 residents reviewed (R4) who sustained two brain bleeds and a fracture. This resulted in an immediate jeopardy (IJ). In addition to the resident in immediate jeopardy, the facility failed to implement person centered fall interventions and complete a fall analysis for 1 of 3 residents reviewed (R1) who had multiple falls and fractures identified which resulted in actual harm.The immediate jeopardy began on 10/16/25, when R4 returned to the facility from a hospital stay related to her injuries that were sustained after she fell from the fully body mechanical lift during a transfer and upon returning from the hospital there were no immediate interventions implemented to prevent re-occurrence, and was identified on 10/20/25. The administrator, director of nursing (DON), and assistant director of nursing (ADON) were notified of the immediate jeopardy at 6:15 p.m. on 10/20/25. The immediate jeopardy was removed on 10/22/25, but noncompliance remained at the lower scope and severity level 3, G scope and severity level, which indicated actual harm that is not immediate jeopardy.Findings include:R4's quarterly Minimal Data Set (MDS) dated [DATE], indicated R4 had diagnoses which included hereditary and idiopathic neuropathy, polyneuropathy, chronic kidney disease stage 3, anxiety disorder, and morbid obesity.R4's care plan dated 3/16/25, indicated R4 had actual impaired functional status related to impaired gait and mobility, neuropathy, osteoarthritis, depression, opioid use, antipsychotic use and required staff assistance with transfers using Hoyer (full body mechanical lift) assistance of two staff members and a large sling. R4's care plan was revised on 10/19/25, three days after R4 returned to the facility on [DATE], to include Hoyer sling to be removed from underneath resident after every transfer.R4's Fall-witnessed report dated 10/14/25 at 2:35 p.m., indicated writer was alerted to a resident fall that occurred in the resident's room during a transfer from a lift. A small amount of blood was noted on the floor, as well as on the resident's [R4] left ear and the left lower head just above the hairline. The resident was alert and oriented and verbalized just get me off the floor. Range of motion was limited but within normal limits per her usual restrictions. The resident reported mild pain to the left posterior shoulder and right knee. The resident refused to have vital signs obtained prior to being assisted from the floor. A lift sheet was properly positioned, and the resident was assisted from the floor using a Hoyer lift with assistance from four staff members. Resident and staff were interviewed following the incident. The care plan was followed at the time of the fall, and the staffs transfer technique was observed immediately after the fall with no concerns noted. The resident was able to answer questions appropriately and participate in the assessment. R4's progress notes revealed the following:-On 10/14/25 at 2:35 p.m., R4 was being transferred with assist of two staff members and R4 fell from the lift.-On 10/15/25, R4 was transferred to another hospital related to bleeding in the brain.-On 10/15/25, R4 was admitted to another hospital related to diagnosis of Traumatic subarachnoid and subdural hemorrhage. No tentative return date at this time. -On 10/16/25, R4 returned to the facility at approximately 2:15 p.m., from the hospital. R4 was admitted for intracranial bleeding due to fall. Transfers with Hoyer lift and assist of two staff with a medium sling.-On 10/19/25 at 12:43 p.m., a RN (registered nurse) Post Fall Follow-Up was completed. R4 continued to have pain in neck and right leg/knee. New intervention initiated was Hoyer sling to be removed from under resident after all transfers are completed and to be replaced behind resident for any further transfers. This would ensure sling is properly placed behind resident with every transfers. Root cause of resident's fall was determined to be the sling may not have been properly positioned behind resident while resident was being transferred resulting in resident not being secured.On 10/19/25 at 3:52 p.m., R4 transferred to the emergency room (ER) due to possible DVT (deep vein thrombosis).On 10/19/25 at 9:10 p.m., R4 returned to the facility by ambulance. R4 was diagnosed with peri-prosthetic distal transverse femur fracture. New orders to wear knee immobilizer whenever movement was occurring and Hydrocodone every 4-6 hours as needed for pain.On 10/16/25 at 9:14 a.m., family member (FM)-A stated they were notified following the fall from the lift and R4 was brought to the ER and then transferred to another hospital due to two brain bleeds. FM-A stated R4 was unsure what happened or what caused the fall.On 10/16/25 at 9:29 a.m., nursing assistant (NA)-A stated R4 required assist of two staff members and utilized a Hoyer lift for transfers. NA-A stated on 10/14/25 at approximately 2:30 p.m., R4 put on her call light and requested staff assistance with incontinence cares. NA-A stated she transferred R4 out of her electric wheelchair into R4's bed with assistance by NA-B, and there were no issues. NA-A stated staff