Electronically Delivered

November 04, 2026

Licensee
Glenwood Estates
500 Franklin Street North
Glenwood, MN 56334

RE: Project Number(s) SL22169016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 21, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment = $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22169	A. BUILDING: _____ B. WING _____	09/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD ESTATES	500 FRANKLIN STREET NORTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL22169016-0 On September 15, 2026, through September 21, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 23 resident(s); 23 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=G	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to MAARC for one of one resident (R4) who had a delay in care after regional registered nurse (RRN)-C failed to implement a medication change following an emergency room visit. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee with a diagnosis	0 620		

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0 620	Continued From page 3 of dementia and started receiving assisted living services on October 20, 2025. R4's service plan dated July 27, 2026, indicated R4 received medication assistance. R4's medication management plan dated July 24, 2026, indicated R4 required assistance with medication administration, and the licensed practical nurse (LPN) and registered nurse (RN) manage changes to medication regimen. On September 16, 2026, at approximately 1:30 p.m., R4's daughter notified the survey team that R4 was transported to the emergency room via ambulance on September 6, 2026, due to symptoms of urinary tract infection (UTI) and dehydration. R4's daughter stated R4 received a new prescription for an antibiotic, however staff failed to implement the new medication order for several days. On September 6, 2026, at 11:24 a.m., regional registered nurse (RRN)-C completed a Resident Note indicating RRN-C instructed unlicensed personnel to send R4 to the hospital due to recent changes of status. On September 6, 2026, at 10:22 p.m., registered nurse (RN)-I completed a Resident Note indicating R4 returned to the facility. On September 8, 2026, at 7:57 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A completed a Resident Note stating R4 had been seen in the emergency department on September 6, 2026, and was diagnosed with a UTI. A prescription for cephalexin, take 1 pill by mouth three times a day for seven days, was ordered and the pharmacy was aware.	0 620		

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0 620	Continued From page 4 LALD/LPN-A indicated the electronic medical record (EMAR) was updated and staff were notified. On September 11, 2026, at 4:53 p.m., RRN-C completed a Resident Note stating RRN-C received a call from a RN at R4's clinic regarding the cephalexin order. RRN-C informed the RN that the medication had not been received from the pharmacy. RN from the clinic stated the resident needed to start the medication and a new order would be sent to the pharmacy. RRN-C notified the director and updated the EMAR. R2's medication administration record (MAR) indicated the cephalexin was started on September 14, 2026, eight days after the medication was prescribed. On September 16, 2026, at 9:17 a.m., LALD/LPN-A stated she had been on vacation following the Resident Note she entered on September 8, 2026, and it was an oversite by RRN-C. On September 16, 2026, at 2:10 a.m., RRN-C stated the pharmacy did not deliver it and RNN-C failed to follow-up with the provider, pharmacy, or other nursing staff. She stated the delay in medication administration was her error and she failed to complete a MAARC report for the medication error. The licensee's 2.25 Report of Maltreatment of a Vulnerable Adult policy revised on August 11, 2021, indicated consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [the facility] prohibits the maltreatment of residents. Types of maltreatment	0 620		

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0 620	Continued From page 5 include neglect, abuse, or financial exploitation. All team members are mandated reporters of maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees, unlicensed	0 660		

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0 660	Continued From page 6 personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility had a current TB risk assessment that indicated the facility was at a low risk for TB transmission. ULP-E was hired November 21, 2024, to provide direct care services to residents. ULP-E's record lacked a two-step TST or other evidence of TB screening such as a blood test. On September 17, 2026, at 2:42 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-E did not have documentation of TB testing. LALD/LPN-A stated it was an oversite and she was aware of the TB requirements. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before	0 660		

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0 660	Continued From page 7 hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's 8.07 Tuberculosis and Staff Screening policy reviewed/dated March 27, 2025, indicated all assisted living personnel whose essential job functions require work within the same air space of residents shall be screened and tested for tuberculosis and personnel TB screening results shall be kept in each team member file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 775		

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0 775	Continued From page 8 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 9 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days..	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 10 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 810		

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0 810	Continued From page 11 September 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to administer medications according to provider orders for one of one resident (R4). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22169	A. BUILDING: _____ B. WING _____	09/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD ESTATES	500 FRANKLIN STREET NORTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 12 situation has occurred only occasionally). The findings include: R4 was admitted to the licensee with a diagnosis of dementia and started receiving assisted living services on October 20, 2025. R4's service plan dated July 27, 2026, indicated R4 received medication assistance. R4's medication management plan dated July 24, 2026, indicated R4 required assistance with medication administration, and the licensed practical nurse (LPN) and registered nurse (RN) manage changes to medication regimen. On September 15, 2026, at approximately 1:30 p.m., R4's daughter notified the survey team that R4 was transported to the emergency room via ambulance on September 6, 2026, due to symptoms of urinary tract infection (UTI) and dehydration. R4's daughter stated R4 received a new prescription for an antibiotic, however staff failed to implement the new medication order for several days. On September 6, 2026, at 11:24 a.m., regional registered nurse (RRN)-C completed a Resident Note indicating RRN-C instructed unlicensed personnel to send R4 to the hospital due to recent changes of status. On September 6, 2026, at 10:22 p.m., registered nurse (RN)-I completed a Resident Note indicating R4 returned to the facility. On September 8, 2026, at 7:57 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A completed a Resident Note stating	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22169	A. BUILDING: _____ B. WING _____	09/21/2026

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01760	Continued From page 13 R4 had been seen in the emergency department on September 6, 2026, and was diagnosed with a UTI. A prescription for cephalexin, take 1 pill by mouth three times a day for seven days, was ordered and the pharmacy was aware. LALD/LPN-A indicated the electronic medical record (EMAR) was updated and staff were notified. On September 11, 2026, at 4:53 p.m., RRN-C completed a Resident Note stating RRN-C received a call from a RN at R4's clinic regarding the cephalexin order. RRN-C informed the RN that the medication had not been received from the pharmacy. RN from the clinic stated the resident needed to start the medication and a new order would be sent to the pharmacy. RRN-C notified the director and updated the EMAR. R2's medication administration record (MAR) indicated the cephalexin was started on September 14, 2026, eight days after the medication was prescribed. On September 16, 2026, at 9:17 a.m., LALD/LPN-A stated she had been on vacation following the Resident Note she entered on September 8, 2026, and it was an oversite by RRN-C. On September 16, 2026, at 2:10 a.m., RRN-C stated the pharmacy did not deliver it and RNN-C failed to follow-up with the provider, pharmacy, or other nursing staff. She stated the delay in medication administration was her error and she failed to complete a MAARC report for the medication error. On October 24, 2022, Mayo Clinic Press	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22169	A. BUILDING: _____ B. WING _____	09/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD ESTATES	500 FRANKLIN STREET NORTH GLENWOOD, MN 56334

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01760	Continued From page 14 (publishing division of May Clinic) published an article indicating the following: "If an infection isn ' t treated, it can lead to serious problems. UTIs rarely lead to complications when treated promptly and properly. But an untreated UTI can turn into a kidney infection, which can lead to permanent kidney damage. There is also the risk of sepsis, a potentially life-threatening complication." The licensee's 12.27 Medication and Treatment Orders- Implementing policy revised on August 11, 2021, indicated medication and treatment/therapy orders received must be implemented within 24 hours of receipt. Upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GLENWOOD ESTATES
500 Franklin Street North
Glenwood, MN 56334
Pope County
Parcel:

Phone:

License Info

License: HFID 22169

Risk:
License:
Expires on:
CFPM: Jennifer Kay Cockford
CFPM #: 24201; Exp: 01/20/2028

Inspection Info

Report Number: F7935261120
Inspection Type: Full - Single
Date: 9/15/2026 Time: 11:23:16 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Fergus Falls District Office inspection report number F7935261120 from 9/15/2026

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

GLENWOOD ESTATES
Glenwood
County/Group: Pope County

Inspection Info

Report Number: F7935261120
Inspection Type: Full
Date: 9/15/2026
Time: 11:23:16 AM

Food Temperature: Product/Item/Unit: Cut Melons**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Pork Chops**; Temperature Process:** Cooking
Location: Oven at 202 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

GLENWOOD ESTATES
Glenwood
County/Group: Pope County

Inspection Info

Report Number: F7935261120
Inspection Type: Full
Date: 9/15/2026
Time: 11:23:16 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL22169016	**Date:** 9/14/2026
Facility Name: Glenwood Estates	
Facility Address: 500 Franklin Street North Glenwood MN 56334	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: It was observed that there were no carbon monoxide alarms installed outside and within 10 feet of all sleeping rooms. The facility was equipped with a fuel-burning water heater, furnace, and stove that all have the potential to produce carbon monoxide.

3. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: The fire rated door that went into the kitchen was removed.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety,

comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

Resident room 112 had a bed frame blocking the egress window in one of the bedrooms.
Resident room 114 had a bed frame, wheelchair, chair and various other personal items blocking the egress.
Resident room 115 had a sewing machine and bench blocking the way of egress.
Resident room 109 had a bed frame blocking the egress window.
Resident room 107 had a sewing machine blocking the egress window.
Resident room 104 had a sewing machine in front of the egress window.
Resident room 103 had a computer desk in front of the egress window. This room had a fence installed around the entrance door which was blocking the way of egress. The room was very cluttered. The carpet was heavily stained throughout and was coming up in some areas. The walls had scratches and holes in them due to the wheelchair.
Resident room 105 had cat feces on the carpet in the bedroom.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Fire safety and Evacuation drills were conducted quarterly. Licensed assisted living director/clinical nurse specialist LALD/LPN-A stated that the fire drills were being done quarterly, and they were not aware of the requirements.