



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 2026

Administrator
GREEN PINE ACRES NURSING HOME
427 MAIN STREET NORTHEAST
MENAHA, MN 56464

RE: CCN: 245563

Cycle Start Date: January 28, 2026

Dear Administrator:

On April 7, 2026, we notified you a remedy was imposed. On March 18, 2026 and May 6, 2026 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 16, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 28, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 7, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 28, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 16, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, slightly slanted style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 2026

Administrator
GREEN PINE ACRES NURSING HOME
427 MAIN STREET NORTHEAST
MENAHA, MN 56464

Re: Reinspection Results
Event ID: 1DDF92-H2

Dear Administrator:

On March 18, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 28, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0000	Initial Comments On 1/26/26 through 1/28/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.		E0000			02/19/2026	
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible,		E0039	It is the policy of Green Pine Acres to provide EP Testing requirements in accordance with CFR 483.73 to analyze the facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the facility's emergency plan as needed. Green Pine Acres staff and residents participated in a mock fire drill on February 2, 2026 with the Menahga, Sebeka, Park Rapids, Wolf Lake Fire Departments. A community-based exercise was performed with evacuation and search of residents. An after-incident meeting was conducted to identify what went well and areas of improvement. An after-action plan was completed. All Staff will be educated on the full-scale drill and necessary changes that were identified by 3/13/2026. The training/ action plan will be integrated into the quality assurance program and evaluated for its effectiveness by Administrator or designee, who will monitor compliance with the annual drill requirement. QA meeting will set drills for 2026 and review 3/20/2026.		03/13/2026	

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 reverse for further 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
---	--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
E0039 SS = F	Continued from page 1 conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following			E0039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0039 SS = F	Continued from page 2 the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency		E0039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0039 SS = F	Continued from page 3 plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct		E0039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0039 SS = F	Continued from page 4 exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional		E0039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0039 SS = F	Continued from page 5 exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:		E0039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0039 SS = F	Continued from page 6 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a		E0039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
E0039 SS = F	Continued from page 7 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by:			E0039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
E0039 SS = F	Continued from page 8 Based on interview and document review, the facility failed to conduct exercises to test its emergency preparedness (EP) program at least twice per year. This had the potential to affect all 56 residents currently residing in the facility, as well as the staff. Findings include: The facility's EP plan identified that the facility had only conducted one of the two required exercises to test the EP plan, which included a potential full-scale exercise, a mock disaster drill, or a tabletop exercise, and analyzed the facility's response to an additional exercise. During an interview on 1/28/26 at 2:09 p.m., the administrator stated they had completed one drill in the past year. There were plans for a second community wide drill, but it had not been completed. The facility's undated Emergency Preparedness Training and Testing Program policy identified testing exercises using emergency procedures will be conducted at least twice per year.		E0039				
F0000	INITIAL COMMENTS		F0000			03/14/2026	
	On 1/26/26 through 1/28/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.						
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records		F0755	It is the policy of Green Pine Acres to provide medication administration in accordance with CFR 483.45 (a)(b) to ensure that each resident safely receives the appropriate medications.		03/13/2026	
	CFR(s): 483.45(a)(b)(1)-(3)						
	§483.45 Pharmacy Services			A new medication order and medication was obtained for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENA HGA, Minnesota, 56464	
(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) COMPLETION DATE
F0755 SS = D	Continued from page 9 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow their policies, and or acceptable standards of practice, to ensure medication administration accuracy for 2 of 2 residents (R23, R66) reviewed for narcotic count accuracy. Findings include: R23's comprehensive Minimum Data Set (MDS) dated 12/19/25, identified R23 was cognitively aware and had diagnoses that included breast cancer, heart failure, and chronic obstructive pulmonary disease (COPD). R23 was receiving hospice services. R23's physician order dated 12/5/25, identified lorazepam oral tablet 0.5 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 14 Days. Call Hospice prior to administering the	F0755	Continued from page 9 R23 and old medication was destroyed. R66 is deceased. Performed an audit of all narcotics, assuring they are in original packaging and medication label matches medication, narcotic book and medication order. Medication training has been scheduled with the pharmacy consultant on 2/24/2026. All RN, LPN, TMA Staff will be educated following the 5 rights of medication administration including administering medication, medication reconciliation and medication error reporting. Staff will be re-educated on policies and procedures by 3/13/2026. The policy/procedure and training will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will monitor compliance with the procedure by random audits. Audits will be performed once weekly x4 weeks. Findings will be brought to QA meeting and reviewed for compliance and re-evaluation 3/20/2026 until compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
F0755 SS = D	Continued from page 10 first dose – must chart non-pharmacological interventions attempted. R23's Medication Administration Record dated December 2025, identified lorazepam oral tablet 0.5 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 14 Days. Call Hospice prior to administering the first dose – must chart non-pharmacological interventions attempted. However, the record did not identify R23 ever received the medication. The undated black, bound Individual Narcotic Record identified on page 97 R23's lorazepam was received on 12/5/25 with an RX number (a unique identifier assigned to a prescription) of 4004867 518 with five 0.5 milligram (mg) tablets received. On 12/29/25, a handwritten entry identified two tablets were administered to R23 by trained medication aide (TMA)-B, however, this line was scratched out and underneath the quantity remaining identified 5 along with licensed practical nurse (LPN)-B's signature. A sticky paper was attached to the page with a handwritten note that stated, "5 different tabs/code ½ tabs are 0.5 mg JA RN". During an observation on 1/26/26 at 6:11 p.m., R23's lorazepam bottle held three 0.5 mg tablets of lorazepam and a 1 mg tablet of lorazepam broken into two pieces totaling five 0.5 mg tablets. R66's undated Admission Record, identified R66 was admitted to the facility on 12/11/25 and had diagnosis that included cancer and palliative care. R66's Order Summary Report dated 12/12/25, identified lorazepam oral tablet 1 mg tablets. Give 1 tablet by mouth four times a day for anxiety/shortness of breath (SOB). – every 6 hours around the clock (ATC). R66's Medication Administration Record dated December 2025, identified R66 received lorazepam 1 mg on 12/29/25 at 7:00 p.m. The undated black, bound Individual Narcotic Record identified on page 126 R66's lorazepam was received on 1211/25 with an RX number (a unique identifier assigned to a prescription) of 4005034. On 12/29/25 at 6:48 p.m., a handwritten entry identified 1 tablet were administered to R66 by TMA-B. During an interview on 1/26/26 at 7:11 p.m., LPN-B stated she was aware of a discrepancy with R66 and R23's lorazepam narcotic count, but it had been a long		F0755				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
F0755 SS = D	Continued from page 11 time since that happened and didn't recall the date nor what occurred. LPN-B did recall replacing the tablets in R23's lorazepam prescription bottle because they're the same strength even though it was a 1 mg tablet broken in half. LPN-B stated no staff were directed to not take from one medication bottle and put in another, but R23's medication was mistakenly used for R66. "So, they were just replaced." LPN-B stated TMA-B had mistakenly used R23's medication for R66 and LPN-B only "fixed it." During an interview on 1/26/26 at 7:14 p.m., TMA-B stated on 12/29/25 he mistakenly administered R23's lorazepam tablets to R66. TMA-B stated he realized his error as soon as he documented the administration on page 97 under R23. TMA-B stated he immediately brought the error to LPN-B. TMA-B nor LPN-B completed a medication error report nor reported the error to administration. During an interview on 1/26/26 at 7:27 p.m., LPN-B stated the incident was a medication error because the medication was administered to the wrong resident and the tablet dose did not match the medication order. LPN-B stated TMA-B should have realized it was the incorrect medication when comparing the bottle to the medication order. LPN-B stated she did not inform administration because LPN-B replaced the medication in the bottle and thought "it wasn't a big deal." During a telephone interview on 1/27/26 at 9:34 a.m., the pharmacist stated he was unaware of a medication error involving R23 and R66's lorazepam and stated the facility must complete a medication error report. Stated staff were not allowed to "borrow" medications between residents for medication safety and for tracking of medications. Education would be provided to the staff to ensure all staff were aware of the process and what to do in the future. During an interview on 1/28/26 at 11:39 a.m., registered nurse (RN)-A stated when a discrepancy or incorrect medication was used in error a medication error report was completed. The report was a paper form and once completed was given to RN-A. RN-A would do an investigation of what happened and then provide education to the staff involved. After that, the form would be given to the director of nursing (DON). RN-B stated she was unaware of error when R23's lorazepam was used until 1/27/25. Afterwards, the pharmacist was contacted to get his recommendations. RN-A stated LPN-B completed a medication error report on 1/27/25. Staff had been told not to "borrow" medications from residents to use for another and to notify pharmacy,		F0755				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
F0755 SS = D	Continued from page 12 the RN in charge, and the resident's provider. During an interview on 1/28/26 at 11:55 a.m., the DON stated she was notified of the medication error on 12/27/25 when the person involved came forward and "wrote herself up." When a staff member makes a medication error, they complete a medication error report and give it to the unit manager or the DON. Then, either the unit manager or the DON, provide one-to-one education to the staff member and then do an audit to ensure further education did not need to occur. The DON stated when LPN-B explained the situation, LPN-B didn't realize replacing the medication was wrong. LPN-B thought it was an easy fix, and she had been educated on how the process should have been. Normally, the DON would expect staff to report it as a medication error. The DON stated there were a couple reasons why staff could not "borrow" from one resident's medications for another resident. First, the pharmacist dispenses medications and there is a process to ensure medications were correct and it was best practice in having more than one person involved to ensure safety. Additionally, there was the financial piece as well because the medication belongs to the resident. Further, it was best practice to be aware of the error because LPN-B had never incurred a situation like that and just didn't realize it was an error. All staff could learn from that. During an interview on 1/28/26 at 2:21 p.m., the administrator stated she expected staff to inform the DON of all medication errors when identified and to follow facility policy. The facility policy Medication Administration revised 5/22/24, identified the six {6} rights of medication administration should be followed with each medication or treatment. These include right resident, medication, dose, time, route, and documentation. A facility policy regarding medication error was requested but not received.		F0755				
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.		F0761	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. It is the policy of Green Pine Acres to provide medication administration in accordance with CFR		03/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464	
(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) COMPLETION DATE
F0761 SS = E	Continued from page 13 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were secured for 2 of 2 residents (R2, R4) observed unattended on the Transitional Care Unit (TCU). In addition, the facility failed to ensure safe refrigeration temperatures were maintained for 1 of 4 medication refrigerators (TCU Fridge C) reviewed for medication storage. This had the potential to affect residents residing on the TCU. Findings include: Medication Left Unattended: R2's significant change Minimum Data Set (MDS) dated 12/26/25, identified R2 was cognitively intact and had diagnoses including heart disease and diabetes. R2 received daily injections of insulin. R2's medication order report dated 1/28/26, identified Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 9 unit subcutaneously in the morning for DMII, order date 1/19/26. R4's admission MDS dated 1/16/26, identified R4 was cognitively intact and had diagnoses including renal insufficiency, and diabetes. R4 received daily insulin injections. R4's medication order report dated 1/28/26 identified Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 10 unit subcutaneously two times a day for DMII, order date 1/22/26.	F0761	Continued from page 13 483.45(h), to ensure that drugs and biologicals are stored in locked compartments under the proper temperature controls and only authorized personnel have access to the keys. Medication training has been scheduled with the pharmacy consultant on 2/24/2026. All RN, LPN, TMA Staff will be educated on following the 5 rights of medication administration and education on risk of leaving medications unattended. All Staff will be educated, and policies & procedures will be reviewed by 3/14/2026 A new schedule for checking refrigerator temperatures has been created. The location of the schedule will be on the refrigerators with a reminder on the med carts. All Staff were educated 2/06/2026 and 2/09/2026 on new schedules and procedure. The policy/procedure and training will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will monitor compliance with the procedure by random audits. Audits will be performed once weekly x4 weeks. Findings will be brought to QA meeting and reviewed for compliance and re-evaluation 3/20/2026 until compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
F0761 SS = E	Continued from page 14 On 1/28/26 at 7:16 a.m., trained medication aide (TMA)-A was standing at a TCU medication cart prepping medication for a resident. The medication cart was against the wall next to the nurse’s desk and in the same area as a larger common area used as the dining room. There were two residents seated at different tables in the area and no staff in the visible area near or around the medication cart. There were two labeled insulin Solostar pens on the corner of the medication cart belonging to R2 and R4. TMA-A was standing at the medication cart, facing the wall with her back to the dining area and prepped and picked up supplies to check a resident’s blood sugar. TMA-A turned away from the medication cart, walked into the dining area. TMA-A followed the residents across the dining area, into their room and checked the residents’ blood sugar. leaving the insulin back to the medication cart unattended. TMA-A was unable to observe the medications while in the resident’s room and checking their blood sugar. Directly following the observation TMA-A stated she had set the insulin pens on the medication cart, just left them there and walked away while one other male resident was seated in the dining room. The risk of leaving insulin and/or medications on the cart was that someone else could pick up the medication and use it. TMA-A stated she should not have left the insulin pens unattended on the medication cart. On 1/28/26 at 7:26 a.m., licensed practical nurse, (LPN)-A walked to the medication cart and removed the two insulin pens from the cart. LPN-A stated there were residents that wheeled around the unit without staff assistance and the insulin pens should not have been left unattended on the cart. The risk of leaving medications unattended was that someone else could take the medications. On 1/28/26 at 8:02 a.m., registered nurse (RN)-A stated medications should not be left unattended on medication carts. The risk of leaving medications unattended was someone else picking them up and using them. The facility Medication Storage policy dated 2/22/24, included all drugs would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) and during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Medication Refrigerator Temps: The TCU fridge temperature log dated Jan/Feb 2026,		F0761				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
F0761 SS = E	Continued from page 15 identified nine columns and four rows across the page. The form had instructions for the PM shift and NOC shift. They were to check the temperatures each day and document their initials and record the temperature in the box. At the end of the month staff were to place the form in the DON's box. Columns across the top identified a section labeled PM and NOC shift and one column for each day of the week, Monday through Sunday. Rows across the page identified week one through week four, and had two boxes (one for PM shift and one for NOC shift) for staff to document their initials and fridge temp. Instructions typed across the bottom of the page identified if temps were less than 36 degrees or greater than 46 degrees staff were to report to DON and maintenance and to keep the form in the narcotic book to ensure it was not forgotten as it was required. The form identified there were eight temperatures recorded that were less than the recommended 36-degrees along with six missed entries. The TCU medication room observation was completed on 1/28/26 at 8:08 a.m., with registered nurse (RN)-A. There were two unlocked refrigerators - one under the sink cabinet (C) and a smaller fridge on the floor (F). RN-A stated fridge temps are monitored twice daily, once on the evening shift and once on the night shift and staff were to document on the fridge temp log. At the end of the month the logs were sent to the DON. Fridge temps were to be maintained between 36- and 46-degrees Fahrenheit (F) and staff were instructed to contact maintenance if the temps were out of range. RN-A stated during the month of January 2026, there were five entries where fridge C was out of range, and six days and 12 occasions that the log was blank indicating the temp was not checked. Fridge C contained resident medications including Lantus insulin, NovoLog insulin, T-Dap, Prevnar, and COVID vaccines. On 1/28/26 at 9:50 a.m., the director of nursing (DON) stated staff on the units were supposed to check and document the fridge temps twice daily. At the end of the month the forms were sent to the DON. The DON stated she did not review the forms and assumed the unit managers reviewed the logs before sending them to her (the DON). The nursing staff were instructed to contact maintenance, as well as herself, if there were issues with the fridges. The DON stated she was unaware of any out-of-range temps for the TCU fridges for the month of January. DON reviewed the January 2026 fridge temp log and stated 5 entries were less than the recommended 36 degrees F and six days were left blank. On 1/28/26 at 11:49 a.m., the pharmacist stated the facility should check their fridge temps according to		F0761				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
F0761 SS = E	Continued from page 16 their policy and if the temps fell out of range, they should follow their policy as well as contact the pharmacist for review of medication recommendations regarding low/high temp exposure. The pharmacist stated he did not have any immediate concerns regarding the low temps although he would have to reach out to the facility and review an itemized list of the medications in the fridge and the recommendations to be sure. On 1/28/26 at 12:47 p.m., the DON stated RN-A had contacted the pharmacy earlier and discussed each of the medications in fridge C. The pharmacist recommended the following medications be destroyed and replaced:One Lantus Solostar penOne Novolog Solostar penOne Prevnar injectionOne T-Dap vaccineOne COVID vaccineThe facility Medication Fridge Policy dated 9/12/19 identified the medication fridge should be checked twice daily and the goal range was between 36- and 46-degrees F. Anything outside of range should be reported to the DON and maintenance.		F0761				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/26/26 through 1/28/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			03/20/2026	

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infbulletins/ib14_1.html . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.		20000				
21605	Stock Medications; Prohibitions. CFR(s): MN Rule 4658.1335 Subp. 3 Subp. 3. Prohibitions. No prescription drug supply for one resident may be used or saved for the use of another resident in the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow their policies, and or acceptable standards of practice, to ensure medication administration accuracy for 2 of 2 residents (R23, R66)		21605	Corrected		02/20/2026	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
21605	Continued from page 2 reviewed for narcotic count accuracy. Findings include: R23's comprehensive Minimum Data Set (MDS) dated 12/19/25, identified R23 was cognitively aware and had diagnoses that included breast cancer, heart failure, and chronic obstructive pulmonary disease (COPD). R23 was receiving hospice services. R23's physician order dated 12/5/25, identified lorazepam oral tablet 0.5 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 14 Days. Call Hospice prior to administering the first dose – must chart non-pharmacological interventions attempted. R23's Medication Administration Record dated December 2025, identified lorazepam oral tablet 0.5 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 14 Days. Call Hospice prior to administering the first dose – must chart non-pharmacological interventions attempted. However, the record did not identify R23 ever received the medication. The undated black, bound Individual Narcotic Record identified on page 97 R23's lorazepam was received on 12/5/25 with an RX number (a unique identifier assigned to a prescription) of 4004867 518 with five 0.5 milligram (mg) tablets received. On 12/29/25, a handwritten entry identified two tablets were administered to R23 by trained medication aide (TMA)-B, however, this line was scratched out and underneath the quantity remaining identified 5 along with licensed practical nurse (LPN)-B's signature. A sticky paper was attached to the page with a handwritten note that stated, "5 different tabs/code ½ tabs are 0.5 mg JA RN". During an observation on 1/26/26 at 6:11 p.m., R23's lorazepam bottle held three 0.5 mg tablets of lorazepam and a 1 mg tablet of lorazepam broken into two pieces totaling five 0.5 mg tablets. R66's undated Admission Record, identified R66 was admitted to the facility on 12/11/25 and had diagnosis that included cancer and palliative care. R66's Order Summary Report dated 12/12/25, identified lorazepam oral tablet 1 mg tablets. Give 1 tablet by mouth four times a day for anxiety/shortness of breath (SOB). – every 6 hours around the clock (ATC).			21605			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
21605	Continued from page 3 R66's Medication Administration Record dated December 2025, identified R66 received lorazepam 1 mg on 12/29/25 at 7:00 p.m. The undated black, bound Individual Narcotic Record identified on page 126 R66's lorazepam was received on 1211/25 with an RX number (a unique identifier assigned to a prescription) of 4005034. On 12/29/25 at 6:48 p.m., a handwritten entry identified 1 tablet were administered to R66 by TMA-B. During an interview on 1/26/26 at 7:11 p.m., LPN-B stated she was aware of a discrepancy with R66 and R23's lorazepam narcotic count, but it had been a long time since that happened and didn't recall the date nor what occurred. LPN-B did recall replacing the tablets in R23's lorazepam prescription bottle because they're the same strength even though it was a 1 mg tablet broken in half. LPN-B stated no staff were directed to not take from one medication bottle and put in another, but R23's medication was mistakenly used for R66. "So, they were just replaced." LPN-B stated TMA-B had mistakenly used R23's medication for R66 and LPN-B only "fixed it." During an interview on 1/26/26 at 7:14 p.m., TMA-B stated on 12/29/25 he mistakenly administered R23's lorazepam tablets to R66. TMA-B stated he realized his error as soon as he documented the administration on page 97 under R23. TMA-B stated he immediately brought the error to LPN-B. TMA-B nor LPN-B completed a medication error report nor reported the error to administration. During an interview on 1/26/26 at 7:27 p.m., LPN-B stated the incident was a medication error because the medication was administered to the wrong resident and the tablet dose did not match the medication order. LPN-B stated TMA-B should have realized it was the incorrect medication when comparing the bottle to the medication order. LPN-B stated she did not inform administration because LPN-B replaced the medication in the bottle and thought "it wasn't a big deal." During a telephone interview on 1/27/26 at 9:34 a.m., the pharmacist stated he was unaware of a medication error involving R23 and R66's lorazepam and stated the facility must complete a medication error report. Stated staff were not allowed to "borrow" medications between residents for medication safety and for tracking of medications. Education would be provided to the staff to ensure all staff were aware of the process and what to do in the future.		21605				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
21605	Continued from page 4 During an interview on 1/28/26 at 11:39 a.m., registered nurse (RN)-A stated when a discrepancy or incorrect medication was used in error a medication error report was completed. The report was a paper form and once completed was given to RN-A. RN-A would do an investigation of what happened and then provide education to the staff involved. After that, the form would be given to the director of nursing (DON). RN-B stated she was unaware of error when R23's lorazepam was used until 1/27/25. Afterwards, the pharmacist was contacted to get his recommendations. RN-A stated LPN-B completed a medication error report on 1/27/25. Staff had been told not to "borrow" medications from residents to use for another and to notify pharmacy, the RN in charge, and the resident's provider. During an interview on 1/28/26 at 11:55 a.m., the DON stated she was notified of the medication error on 12/27/25 when the person involved came forward and "wrote herself up." When a staff member makes a medication error, they complete a medication error report and give it to the unit manager or the DON. Then, either the unit manager or the DON, provide one-to-one education to the staff member and then do an audit to ensure further education did not need to occur. The DON stated when LPN-B explained the situation, LPN-B didn't realize replacing the medication was wrong. LPN-B thought it was an easy fix, and she had been educated on how the process should have been. Normally, the DON would expect staff to report it as a medication error. The DON stated there were a couple reasons why staff could not "borrow" from one resident's medications for another resident. First, the pharmacist dispenses medications and there is a process to ensure medications were correct and it was best practice in having more than one person involved to ensure safety. Additionally, there was the financial piece as well because the medication belongs to the resident. Further, it was best practice to be aware of the error because LPN-B had never incurred a situation like that and just didn't realize it was an error. All staff could learn from that. During an interview on 1/28/26 at 2:21 p.m., the administrator stated she expected staff to inform the DON of all medication errors when identified and to follow facility policy. The facility policy Medication Administration revised 5/22/24, identified the six {6} rights of medication administration should be followed with each medication or treatment. These include right resident, medication, dose, time, route, and documentation.			21605			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
21605	Continued from page 5 A facility policy regarding medication error was requested but not received. Suggested Method of Correction: The DON or designee could develop new policies and procedures, train staff, and implement measures to assure residents medications were not administered to other residents. Staff could be re-educated on the importance of the 5 rights of administration and ensure narcotic reconciliation was accurate. The DON or designee could conduct random audits to ensure compliance. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) to determine compliance or the need to re-evaluate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21605				
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were secured for 2 of 2 residents (R2, R4) observed unattended on the Transitional Care Unit (TCU). In addition, the facility failed to ensure safe refrigeration temperatures were maintained for 1 of 4 medication refrigerators (TCU Fridge C) reviewed for medication storage. This had the potential to affect residents residing on the TCU. Findings include: Medication Left Unattended: R2's significant change Minimum Data Set (MDS) dated 12/26/25, identified R2 was cognitively intact and had diagnoses including heart disease and diabetes. R2 received daily injections of insulin. R2's medication order report dated 1/28/26, identified Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 9 unit subcutaneously in the morning for DMII, order date 1/19/26. R4's admission MDS dated 1/16/26, identified R4 was cognitively intact and had diagnoses including renal insufficiency, and diabetes. R4 received daily insulin		21610	Corrected		02/19/2026	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
21610	Continued from page 6 injections. R4's medication order report dated 1/28/26 identified Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 10 unit subcutaneously two times a day for DMII, order date 1/22/26. On 1/28/26 at 7:16 a.m., trained medication aide (TMA)-A was standing at a TCU medication cart prepping medication for a resident. The medication cart was against the wall next to the nurse's desk and in the same area as a larger common area used as the dining room. There were two residents seated at different tables in the area and no staff in the visible area near or around the medication cart. There were two labeled insulin Solostar pens on the corner of the medication cart belonging to R2 and R4. TMA-A was standing at the medication cart, facing the wall with her back to the dining area and prepped and picked up supplies to check a resident's blood sugar. TMA-A turned away from the medication cart, walked into the dining area. TMA-A followed the residents across the dining area, into their room and checked the residents' blood sugar. leaving the insulin back to the medication cart unattended. TMA-A was unable to observe the medications while in the resident's room and checking their blood sugar. Directly following the observation TMA-A stated she had set the insulin pens on the medication cart, just left them there and walked away while one other male resident was seated in the dining room. The risk of leaving insulin and/or medications on the cart was that someone else could pick up the medication and use it. TMA-A stated she should not have left the insulin pens unattended on the medication cart. On 1/28/26 at 7:26 a.m., licensed practical nurse, (LPN)-A walked to the medication cart and removed the two insulin pens from the cart. LPN-A stated there were residents that wheeled around the unit without staff assistance and the insulin pens should not have been left unattended on the cart. The risk of leaving medications unattended was that someone else could take the medications. On 1/28/26 at 8:02 a.m., registered nurse (RN)-A stated medications should not be left unattended on medication carts. The risk of leaving medications unattended was someone else picking them up and using them. The facility Medication Storage policy dated 2/22/24, included all drugs would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) and during a medication pass, medications must be under the direct		21610				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
21610	Continued from page 7 observation of the person administering medications or locked in the medication storage area/cart. Medication Refrigerator Temps: The TCU fridge temperature log dated Jan/Feb 2026, identified nine columns and four rows across the page. The form had instructions for the PM shift and NOC shift. They were to check the temperatures each day and document their initials and record the temperature in the box. At the end of the month staff were to place the form in the DON's box. Columns across the top identified a section labeled PM and NOC shift and one column for each day of the week, Monday through Sunday. Rows across the page identified week one through week four, and had two boxes (one for PM shift and one for NOC shift) for staff to document their initials and fridge temp. Instructions typed across the bottom of the page identified if temps were less than 36 degrees or greater than 46 degrees staff were to report to DON and maintenance and to keep the form in the narcotic book to ensure it was not forgotten as it was required. The form identified there were eight temperatures recorded that were less than the recommended 36-degrees along with six missed entries. The TCU medication room observation was completed on 1/28/26 at 8:08 a.m., with registered nurse (RN)-A. There were two unlocked refrigerators - one under the sink cabinet (C) and a smaller fridge on the floor (F). RN-A stated fridge temps are monitored twice daily, once on the evening shift and once on the night shift and staff were to document on the fridge temp log. At the end of the month the logs were sent to the DON. Fridge temps were to be maintained between 36- and 46-degrees Fahrenheit (F) and staff were instructed to contact maintenance if the temps were out of range. RN-A stated during the month of January 2026, there were five entries where fridge C was out of range, and six days and 12 occasions that the log was blank indicating the temp was not checked. Fridge C contained resident medications including Lantus insulin, NovoLog insulin, T-Dap, Prevnar, and COVID vaccines. On 1/28/26 at 9:50 a.m., the director of nursing (DON) stated staff on the units were supposed to check and document the fridge temps twice daily. At the end of the month the forms were sent to the DON. The DON stated she did not review the forms and assumed the unit managers reviewed the logs before sending them to her (the DON). The nursing staff were instructed to contact maintenance, as well as herself, if there were issues with the fridges. The DON stated she was unaware of any out-of-range temps for the TCU fridges for the		21610				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
21610	Continued from page 8 month of January. DON reviewed the January 2026 fridge temp log and stated 5 entries were less than the recommended 36 degrees F and six days were left blank. On 1/28/26 at 11:49 a.m., the pharmacist stated the facility should check their fridge temps according to their policy and if the temps fell out of range, they should follow their policy as well as contact the pharmacist for review of medication recommendations regarding low/high temp exposure. The pharmacist stated he did not have any immediate concerns regarding the low temps although he would have to reach out to the facility and review an itemized list of the medications in the fridge and the recommendations to be sure. On 1/28/26 at 12:47 p.m., the DON stated RN-A had contacted the pharmacy earlier and discussed each of the medications in fridge C. The pharmacist recommended the following medications be destroyed and replaced:One Lantus Solostar penOne Novolog Solostar penOne Prevnar injectionOne T-Dap vaccineOne COVID vaccineThe facility Medication Fridge Policy dated 9/12/19 identified the medication fridge should be checked twice daily and the goal range was between 36- and 46-degrees F. Anything outside of range should be reported to the DON and maintenance. SUGGESTED METHOD OF CORRECTION: The DON or designee with conjunction of the consulting pharmacist should review, revise, or create policies and procedures for proper storage of items in the medication room or refrigerators. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21610			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 10, 2026

Administrator
GREEN PINE ACRES NURSING HOME
427 MAIN STREET NORTHEAST
MENAHA, MN 56464

RE: CCN:245563

Cycle Start Date: January 28, 2026

Dear Administrator:

On January 28, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section

above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 28, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 28, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens

State Fire Safety Supervisor

Health Care & Correctional Facilities

MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145

St. Paul, MN 55101

Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/28/2026. At the time of this survey, Green Pine Acres Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			03/05/2026

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 reverse for further 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
---	--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE	
K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Green Pines Acres 1964 Main Building 1-story, partial basement Type II (111) 1969 Addition 1-story, no basement Type II (111) 1996 Administration building and connecting link 1-story, no basement Type V (111) separated with 2-hour rated fire barrier 1999 Laundry addition 1-story, no basement Type II (111) 2004 Kitchen addition 1-story, no basement Type II (111) The building is divided into 4 smoke zones by 30 minute and 90 minute fire barriers. Full automatic sprinkler systems with quick response heads Fire alarm system with smoke detectors in the corridor system, in all common areas and is monitored off site and has automatic fire department notification The facility has a capacity of 65 beds and had a census of 60 at the time of the survey The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:		K0000				
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA		K0324	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's		03/05/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464	
(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) COMPLETION DATE
K0324 SS = D	Continued from page 2 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could an isolated impact on the residents within the facility. The findings include: On 01/28/2026 at 1:07pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and/or any deep fat fryer cooking devices. An interview with the Director of Maintenance and Facility Administrator verified these deficient findings at the time of discovery.	K0324	Continued from page 2 credible allegation of compliance. Green Pine Acres will maintain kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. On 01/28/2026 at 1:07pm during survey, the attachment device was in place behind the gas-fired stove and griddle. On 1/29/2026 a tape was placed on the floor by maintenance staff for an alignment mark to ensure that the appliance is returned to an approved location after it has been moved for maintenance and cleaning. Kitchen and maintenance staff have been educated about the use of the mark on the floor and making sure that the equipment is tethered to the wall after being returned to approved location. The policy/procedure and training will be integrated into the quality assurance program and evaluated for its effectiveness by Administrator or designee, who will monitor compliance with the procedure by random audits. Audits will be performed once weekly x4 weeks. Findings will be brought to QA meeting and reviewed for compliance and re-evaluation 4/18/2026 until compliance	
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K0761	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be	04/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464	
(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) COMPLETION DATE
K0761 SS = F	Continued from page 3 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: 1) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/28/2026 at 11:48am, it was revealed by review of available documentation the required annual door inspection documentation utilizing the 13 point inspection document was not available at the time of the survey. 2) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/28/2026 at the following times, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags.	K0761	Continued from page 3 construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Doors identified by Fire Marshal have been inspected by staff but were manufactured without tags and have a colored dowel/plug to indicate they are fire rated. The doors are in steel frames, and the doors and frames were installed in 1965 and are original doors and frames which are embedded in concrete walls. Green Pine Acres has contacted Intertek, which is a company who will inspect and label all doors that are missing a label and fire rating. The rating and labeling will be completed within 30 days. Facility will inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464	
(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) COMPLETION DATE
K0761 SS = F	Continued from page 4 1) at 12:37pm, North Fire Door - missing tags on door frame 2) at 12:39pm, West Fire Door - missing tags on door and door frame 3) at 12:41pm, South Fire Door - missing tags on door frame An interview with the Director of Maintenance and Facility Administrator verified these deficient findings at the time of discovery.	K0761		
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/28/2026 at the following times, it was revealed	K0920	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Green Pine Acres will maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. All heating and cooling devices have been identified, and staff have determined that no heating or cooling devices or equipment are plugged into power strips. Signage has been placed on blanket warmer to indicate the appliance should not be plugged into a power strip. Electrical Policy has been updated to reflect that no heating or cooling devices or equipment should be plugged into a power strip. Updated policy has been posted to be reviewed by all staff. The policy/procedure will be integrated into the quality assurance program and evaluated for its effectiveness by Administrator or designee, who will monitor compliance with the procedure by random audits. Audits will be performed once weekly x4 weeks. Findings will be brought to QA meeting and reviewed for compliance and re-evaluation 4/18/2026 until compliance.	03/13/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
K0920 SS = E Bldg. 01	Continued from page 5 by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) at 1:01pm - Power-strip with blanket warmer in NW nurse desk 2) at 1:28pm - Power-strip with microwave, coffee maker and refrigerator. An interview with the Director of Maintenance and Facility Administrator verified these deficient findings at the time of discovery.			K0920			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - TEMPORARY CARE ... B. WING		(X3) DATE SURVEY COMPLETED 01/28/2026	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST , MENAHGA, Minnesota, 56464			
(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) COMPLETION DATE
K0000 Bldg. 04	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/28/2026. At the time of this survey, Green Pine Acres Nursing Home Building 04 TCU was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Building 04 is a 16 bed addition for a temporary care unit. It is constructed to a Type V(111) and is separated from the rest of the building by a 2 hour fire barrier. This is a single smoke compartment of 10, 273 square feet and less than 50 occupants. The entire facility is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 16 beds and had a census of 16 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.			K0000			03/05/2026

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 reverse for further 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
---	--	-------	-----------



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 10, 2026

Administrator
GREEN PINE ACRES NURSING HOME
427 MAIN STREET NORTHEAST
MENAHA, MN 56464

Re: State Nursing Home Licensing Orders
Event ID: 1DDF92-H1

Dear Administrator:

The above facility survey was completed on January 28, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, slightly slanted style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112