



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 12, 2026

Administrator

Green Lea Senior Living

115 North Lyndale, Rr 2 Box 49

Mabel, MN 55954

RE: CCN: 245536

Cycle Start Date: July 21, 2026

Dear Administrator:

On July 21, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F), 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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 21, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 21, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 21, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 21, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 21, 2027 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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

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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/21/2026	
NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 , MABEL, Minnesota, 55954			
(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 7/19/26-7/21/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			08/17/2026
F0000	INITIAL COMMENTS On 7/19/26-7/21/26, a standard recertification survey (S#) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55363378C (iQIES # 3030134), H55363379C (iQIES # 3027002), H55363380C (iQIES # 2987161) . NO deficiencies were cited. The following complaints were reviewed: H55362966C (iQIES #3046840) with deficiencies cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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			F0000			

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

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F0000	Continued from page 1 has been attained.			F0000			08/17/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement necessary interventions and provided adequate supervision consistent with the person-centered care plan for 1of 1 resident (R14) reviewed. This deficient practice resulted in actual harm when R14 was left unattended in a shower chair, lost balance, fell to the floor, and sustained a forehead laceration requiring eight sutures and an acute subdural hemorrhage (brain bleed). The noncompliance that began on 6/17/26 was corrected prior to the start of survey when the facility implemented a corrective action plan on 6/22/26. This is issued at past noncompliance. Findings include: Review of R14's Quarterly Minimum Data Set (MDS) assessment, dated 6/10/26 revealed R14 was cognitively intact with no symptoms of delirium and no behavioral expressions. The MDS indicated R14 had limited range of motion in both lower extremities, utilized a wheelchair, was dependent on staff for transfers to/from bed and showers, and was dependent on staff for personal hygiene, bathing, and showering. Review of R14's diagnoses list revealed active diagnoses of Multiple Sclerosis (a disorder affecting muscle movement and control), osteoporosis (a condition causing increased risk of bone fractures), muscle weakness, and unsteady gait. R14's care plan indicated R14 had a self-care performance deficit related to limited mobility. R14 required assistance by 1 staff for bathing and showering, 2 assist to reposition in bed, and 1 assist			F0689	"Past Noncompliance - no plan of correction required"		08/17/2026

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F0689 SS = G	Continued from page 2 for dressing. The care plan also indicated R14 required 1 assist for personal hygiene and was dependent on 2 staff for transfers to and from bed/chair. The care plan was updated 6/17/26 to include R14 was not to be left unattended in the shower. R14's fall risk assessment dated 6/8/26 indicated R14 was at a moderate risk for falls. Review of a facility Incident Progress Note dated 6/17/26 revealed R14 sustained an unwitnessed fall in the shower room, resulting in emergency medical services (EMS) transfer to the emergency room. The note indicated R14 reported she leaned forward and lost her balance. R14 was found on the floor with a laceration to the left forehead, bruising to the left outer shoulder, bruising to the left outer hip, and an abrasion to the left knee. Review of the facility's Root-Cause Analysis (RCA) Report dated 6/17/26 revealed R14 was at risk for falls due to impaired mobility and was left alone in the shower chair. Under environmental factors, the report noted "water running over resident, soap being used for hygiene." Under functional status, the report noted "impaired mobility due to disease process and progression." Review of R14's Hospital Discharge Summary and Neurosurgery Consultation Report dated 6/17/26 revealed R14 sustained head trauma, a left-sided facial laceration, and tenderness to the left outer elbow. Diagnostic imaging revealed an acute right-sided minimal subdural hemorrhage (brain bleed). R14 received eight (8) sutures to repair the forehead laceration and was returned to the facility with monitoring parameters. Review of the facility's post-hospitalization Physician Progress Notes dated 6/22/26 revealed R14 was taking a shower unsupervised on 6/17/26 "because staff were providing privacy." The physician documented: "the plan to prevent this from happening again is for the staff to always remain with [R14] in the bathroom and give her more closer supervision." Interview on 7/20/26 at 11:53 a.m. with NA-B verified that post-incident staff training was effective. NA-B stated she reviews the care plan/Kardex before performing care, received recent shower education, and understands that no resident is ever to be left unattended in the shower room. NA-B stated that any resident requests for solitary showering must be routed through therapy and the			F0689			08/17/2026

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F0689 SS = G	Continued from page 3 charge nurse for safety evaluation. Interview on 7/20/26 at 12:00 p.m. with Occupational Therapist (OT)-A revealed that R14 requires a mechanical lift for all transfers due to severe physical deficits. OT-A stated that a resident's safety to be left alone in a shower depends on both cognition and core abdominal trunk strength. OT-A confirmed that R14 had never been formally assessed by therapy for safety or independent trunk control while seated in the shower chair. Interview on 7/20/26 at 12:38 p.m. with Nursing Assistant (NA)-A revealed that on 6/17/26, she took R14 to the shower room, set her up in the shower chair, and left the room unattended to change the resident's bed linens. NA-A stated that within minutes, she heard a noise and found R14 on the floor bleeding from her head. NA-A stated it had been "customary practice" to leave R14 unattended in the shower room for years because R14 was alert and requested privacy, and that staff checked on her every couple of minutes. NA-A confirmed she knew R14's care plan required an assist of one for showering, but she did not know management was unaware of this custom. Interview on 7/20/26 at 1:13 p.m. with R14 revealed she has always had staff leave her unattended in the shower room during her 4-5 years at the facility. R14 stated that on 6/17/26, "nanoseconds" after the staff member exited the room, she closed her eyes to wash, lost her balance, and fell out of the chair. R14 stated that due to her Multiple Sclerosis, she loses her balance and becomes unstable whenever she closes her eyes. Interview on 7/20/26 at 1:25 p.m. with Registered Nurse (RN)-A revealed she was across the hall when she was alerted R14 was on the floor. R14 was lying on her left side with her arm under her head. R14 had a 1.5-centimeter laceration to her forehead and bruising to the left shoulder, hip, and knee. RN-A stated R14 has a movement disorder affecting her balance and mobility. RN-A stated R14 leaned too far forward, and her legs were not enough to provide a counterbalance causing her to fall. RN-A confirmed R14 is a 1 assist for bathing so facility policy would indicate staff be present during showering; however, it has always been R14's preference to be left unattended. Interview on 7/20/26 at 1:56 p.m. with the Director of Nursing (DON) confirmed she was notified on 6/17/26 that R14 was left alone in the shower and			F0689			08/17/2026

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F0689 SS = G	Continued from page 4 sustained a fall requiring hospital evaluation. The DON confirmed R14 sustained a small brain bleed and a laceration. The DON stated residents should never be left alone in the shower and confirmed R14's care plan indicated 1 assist for bathing. The DON stated she would expect at least 1 staff member to stay with residents in the shower for supervision and assist with showering as the resident needs. A policy titled "Care plans, comprehensive person-centered" dated 3/26 included development of a care plan however did not mention staff expectation for following a resident's care plan. Actions taken included, staff training following the fall included review of bathing and shower/tub policy and procedure as well as care plan, comprehensive person-centered policy and procedure. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.			F0689			08/17/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.			F0578	R22 POLST dated 10/7/25 has been removed with the resident on 8/17/2026 and remains current (CPR Full Code). Other documentation prior to the most recent POLST form of 10/725 has been removed from the facility POLST binder and has be archived into the resident's record. All current residents in the facility will be audited to ensure the resident's advance directives (POLSTS) are accurately and consistency documented in the resident's electronic health record banner, and physician orders to ensure the resident's wishes would be followed in the event of a cardiac arrest. This audit will be completed by date of compliance. Advance Directive policy and procedure was reviewed and updated on 8/14/2026. Facility updated the admission/readmission clinical checklist to ensure the admitting nurse is completing/reviewing the resident's code status with the resident or resident representative upon admission/readmission and ensures the POLST matches the electronic medical record. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following:		08/22/2026

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F0578 SS = D	Continued from page 5 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's advance directives were accurately and consistently documented in the resident's electronic health record (EHR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the resident's wishes would be followed in the event of a cardiac arrest for 1 of 16 residents (R22) reviewed for code status. Findings include: During interview on 7/19/26 at 4:26 p.m., R22 stated the facility did discuss code status with him "a long time ago." R22 confirmed in the event his heart stopped, or he stopped breathing he would want full CPR. R22's Minimum Data Set (MDS) assessment, dated 6/5/26, indicated R22 was cognitively intact with no delirium and no behaviors. R22's form titled "Advanced Directives" dated 5/23/24 indicated "no code". R22's readmission hospital discharge summary dated 10/7/25 indicated "full code". R22's most recent Provider Orders for Scope of Treatment (POST) dated 10/7/25 indicated "full code". R22's April 2026 Electronic Medication Administration Record (EMAR) indicated on the banner at the top of the screen cardiopulmonary resuscitation (CPR)- full code. R22's May 2026 readmission hospital discharge summary dated 5/14/26 indicated "full code"			F0578	Continued from page 5 1) All nurses who complete admissions/readmissions will be educated on the facility Advance Directives, including the updated admission readmission checklist to ensure the code status is reviewed, and reflects in medical the electronic medical record by date of compliance. Education on policy was initiated on 8/17/2026. All licensed nurses will be educated on the facility policy Advance Directives. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2) The Director of Nursing or designee will complete audits on 5 random residents weekly, including all new admissions/readmissions for 3 months to ensure their advance directives are accurately and consistently documented in the resident's electronic health record banner, Provider Order for Life-Sustaining Treatment (POLST), facility POLST binder, and physician orders Audits will be on-going until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.		08/22/2026

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NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 , MABEL, Minnesota, 55954			
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F0578 SS = D	Continued from page 6 R22’s facility signed provider orders 6/16/26 indicated “no code” as of 5/15/26. R22’s July 2026 EMAR banner indicated do not resuscitate (DNR)-No code. During an interview on 7/19/26 at 4:36 p.m., licensed practical nurse (LPN)-A stated if a resident was found without signs of life, she would check code status on the banner in the electronic medical record (EMR). If she questioned the code status, she would check the binder containing the POSTs. LPN-A confirmed the EMR banner indicated R22 was a “no code” and, if found with no signs of life, she would not initiate CPR. LPN-A checked the binder and found an advanced directive for R22 that indicated “no code.” LPN-A confirmed that date of the advanced directive was dated 5/23/24. In a different sleeve of the binder, LPN-A found a POST for R22, dated 10/7/25, that indicated full code. LPN-A confirmed the discrepancy and stated it needed to be clarified. LPN-A stated based on R22’s current banner she would not have needed to check the binder and would not have initiated CPR for R22. During an interview on 7/19/26 at 4:40 p.m., trained medication aide (TMA)-A stated she would check the banner in the Electronic Medical Record (EMR) for code status and would only check the binder if the code status needed to be confirmed. During an interview on 7/19/26 at 5:40 p.m., the director of nursing (DON) stated if a resident is found unresponsive or with no signs of life, she would “go to the orders” to check code status and have someone grab the POST. The DON stated based on R22’s current orders, she would not initiate CPR for R22. The DON then checked the treating clinic portal and R22’s primary clinic portal to verify code status. The DON confirmed both clinic portals indicate R22 should be a full code. The DON then changed R22’s code status from “no code” to “full code”. The DON stated facility staff have limited access to clinic portals however she is always available if there are questions regarding code status. The DON stated the admitting nurse is responsible for verifying code status via admitting paperwork and discussion with the resident and/or responsible party. During a follow-up interview on 7/20/26 at 9:00 a.m., the DON stated R22 was hospitalized in May of 2026 . The DON confirmed R22 was a full code at the time of his hospitalization. On 5/15/26 R22			F0578			08/22/2026

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F0578 SS = D	Continued from page 7 returned to the facility. The DON stated R22 returned with a hospital discharge summary, hospital AVS, and an advanced directive form. The director of nursing stated she changed R22's code status based on the advanced directive for that indicated "no code". The DON reviewed the 5/15/26 discharge summary and AVS and confirmed both indicated R22 was "full code". The DON reviewed the advanced directive form and confirmed it was dated 5/23/24. The DON stated she could not recall if she reviewed the AVS or discharge summary. When asked how hospital orders are verified correctly in the EMR, the DON stated after the admitting nurse should review the entire AVS and enter the orders. The AVS is placed in a basket that directs a second nurse to verify them. The second nurse then signs the orders indicating they were verified. The DON also stated she did not confirm with R22 his code status wishes when she changed to "full code" on 7/19/26. Care conference notes dated 6/9/26 section 1b titled "Current Advanced Directives" indicated "full code" During interview on 7/20/26 at 9:19 a.m., the social services designee (SS)-A stated code status is verified during care conferences. The SS-A confirmed R22's care conference notes dating 6/9/26 indicated R22 was a full code. SS-A stated she verifies the resident's wishes during care conferences by asking them, "if your heart were to stop would you like staff to perform CPR" and puts the response in the care conference notes. SS-A stated she does nothing more with that information. If there was question regarding code status, SS-A stated she believed "nursing staff change it and contact the medical doctor." During a follow-up interview on 7/20/26 at 9:43 a.m., the DON confirmed she was present at R22's care conference on 6/9/26, however does not recall what was discussed regarding code status. The DON verified R22's care conference notes dated 6/9/26 indicated "full code" however "nothing is done with that information unless there is concern." When asked to confirm the admission/readmission process, the DON stated once the admitting nurse enters the orders, they are considered "live". The verifying nurse just compares the AVS and the orders entered and signs the AVS. The DON confirmed R22's hospital AVS dated 5/15/26 did not have a verification signature. During an interview on 7/20/26 at 10:00 a.m., the facility medical director (MD) stated code status must be confirmed when a resident is admitted or readmitted from an acute care facility. If a POST was			F0578			08/22/2026

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F0578 SS = D	Continued from page 8 previously completed, it must be verified with the resident or responsible party. If a discrepancy is found on an advanced directive the facility must verify that with the resident or responsible party and also notify the provider. A policy titled "Advanced Directives" dated 11/2025 defined "advanced directives" as a written instruction, recognized by state law relating to the provisions of health care when the individual is incapacitated. "Do not resuscitate (DNR) indicates, in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy or representative has directed that no cardiopulmonary resuscitation (CPR) or life sustaining treatments or methods are to be used. POST is defined as a form designed to improve patient care by creating a portable medical order form that records the resident's treatment wishes so emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the resident's current medical condition into consideration" The policy also indicated if the resident has an advanced directive, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any staff. The director of nursing or designee notifies the attending physician of advanced directives, or changes in advance directives, that the appropriate orders can be documented in the resident's medical record and plan of care. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advanced directive document in a prominent, accessible location in the medical record and discussing the residents' wishes in care planning meetings. The plan of care for each resident is consistent with their documented treatment preferences and or advanced directive. The interdisciplinary team will review annually with the residents their advance directives to ensure such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The nurse supervisor is required to inform emergency medical personnel of a resident's advanced directives regarding treatment options and provide such personnel with a copy of the advanced directive or POST when transferring from the facility via ambulance or other means.			F0578			08/22/2026

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F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			F0628	R32's discharge on 5/1/2026 will be reported to Ombudsman on 8/19/2026. All residents who have been discharged from the skilled nursing facility or had a transfer to acute care from 7/9/25 to 8/19/2026 will be reported to Ombudsman by date of compliance. Policy, Notification of Ombudsman for Long Term Care, Acute Care Transfers, and Discharge Notification was created on 8/14/2026. Risk of Reoccurrence Administrator of Designee initiating the following: 1) Social service designee will be educated on facility policy, Notification of Ombudsman for Long Term Care, Acute Care Transfers, and Discharge Notification on 8/19/2026. Education included documenting all acute care transfers and discharges on facility log and will be sent to Ombudsman monthly per policy. 2) The administrator will complete audit once monthly that discharge or acute care transfer log was completed and communicated to the MN Office of Ombudsman per policy for three months. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need further auditing and/or additional staff training.		08/22/2026

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F0628 SS = D	Continued from page 10 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the			F0628			08/22/2026

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F0628 SS = D	Continued from page 11 mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with			F0628			08/22/2026

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F0628 SS = D	Continued from page 12 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Ombudsman of the discharge for 1 of 1 resident (R32) reviewed. This practice had the potential to affect all residents who transferred or discharged from September 2025 to July 2026 reviewed for Ombudsman notification. Findings Include R32 record reviewed discharged 5/1/26. R32's record lacked ombudsman notification. During an interview on 07/20/26 3:30 p.m., social service designee (SSD) revealed unaware of the facility ombudsman notification process as SSD was new in the role. On 07/21/2026 6:14p.m., SSD and administrator			F0628			08/22/2026

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F0628 SS = D	Continued from page 13 provided a binder containing logs titled “Monthly Notice to MN Ombudsman for Long Term care of Emergency Acute Care Transfer and Discharge “. The logs were reviewed and indicated, last notification to the Ombudsman was sent on by facsimile was on July 9th, 2025. The facility policy for transfer and discharge was requested and not received.			F0628			08/22/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility			F0641	The MDS coordinator corrected the resident's assessment coding, as indicated by record review and facility review, to ensure the medication use was accurately reflected. The MDS coordinator compared active medication orders against recent MDS assessments for all residents who may have antipsychotic use. Any resident found to have incomplete or inaccurate coding was corrected immediately. Resident care plans were reviewed and care current for antipsychotic use. The MDS coordinator established a standardized pre-submission review checklist for medication-related items. The MDS coordinator will audit 100% of assessments involving antipsychotic medications weekly for the first 30 days. After the initial 30 days, audits will be completed monthly until QAPI deems audits meet substantial compliance. MDS Coordinator - primary responsibility for accurate assessment coding and chart review. Immediate correction for R6: completed upon identification of the deficiency. 8/14/2026. 100% resident chart antipsychotic medication MDS accuracy review: Completed 8/14/26.		08/14/2026

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F0641 SS = D	Continued from page 14 failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R6) reviewed for antipsychotic medication use. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2025, identified Section N: Medications to be completed with an intent to record the number of days, during the last 7 days that select medications were received by the resident to include antipsychotic medications. The manual further indicated, "Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications". Further, the manual provided several coding instructions, including directing staff to "check if an antipsychotic medication was taken by the resident at any time during the 7 day look-back period (or since admission/entry or reentry if less than 17 days)". It also directs staff to "check if there is an indication noted for all antipsychotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days)". The "Antipsychotic medication Review" section directs staff to indicate if the resident received antipsychotic medications since admission/entry or reentry or the prior assessment by answering yes or no. R6's quarterly MDS assessment dated 6/12/26 indicated R6 was cognitively intact. The MDS indicated R6 received antipsychotic medications during the previous 7 days. however the "Antipsychotic medication review" section indicated R7 had not received antipsychotic medications. R6's medication administration record (MAR) dated 6/2026 showed no record R6 received antipsychotic medications during the month. During an interview on 7/21/26 at 3:37 p.m., the facility MDS nurse stated she would "typically" look at the residents MAR to determine medications taken during the observed 7 days of the assessment. If the MAR shows a resident was administered certain medications, she will code it as such on the MDS. The MDS nurse reviewed R6's MAR and confirmed R6 did not receive antipsychotic medications during the observed time. The MDS nurse reviewed R6's quarterly MDS dated 6/12/26 and confirmed she did indicate R6 received antipsychotic medications and			F0641			08/14/2026

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F0641 SS = D	Continued from page 15 there were indications for the administration of the medication. The MDS nurse then reviewed the "antipsychotic medication review" section of the MDS and confirmed she indicated R6 did not receive antipsychotic medications. The MDs nurse stated R6's MDS was one of the first ones she did for the facility and she must have marked "yes" by mistake. During an interview on 7/21/26 at 6:00 p.m., the director of nursing indicated MDS accuracy is important for coordination of residents' care and proper reimbursements rates for the facility. A policy titled "Certifying Accuracy of the Resident Assessment" dated 11/2025 indicated "the information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment." "Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment."			F0641			08/14/2026
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the			F0849	R6 Seroquel medication order prescribed by hospice was initiated per physician orders on 7/22/26. R6"s medication list will be reconciled against the most recent hospice IDG (intradisciplinary group) comprehensive assessment plan of care report. Policy, Hospice Program reviewed and updated on 8/14/2026. The facility has communicated with hospice agencies utilized in the facility that they provide the DON or designee or licensed nurse on duty after hours order-changes or plan of care updates for the resident. It will be the practice going forward that the items will be dated and signed by the licensed nurse who processes the physician orders/plan of care changes. All current residents who receive hospice services will have an audit completed to ensure most recent orders have been implemented by the facility by date of compliance.		08/22/2026

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F0849 SS = D	Continued from page 16 hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are			F0849	Continued from page 16 Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All licensed nurses will be educated on Hospice Program policy and procedures by date of compliance. Education includes reviewing and completing new order changes per hospice plan of care by date of compliance. Education of the policy was initiated on 8/17/26. All on call license nurses who have not worked prior to compliance date will be educated prior to their next scheduled shift. 2) The DON or designee will audit 3 random residents receiving hospice services for three months to ensure order changes or plan of care updates are implemented. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.		08/22/2026

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F0849 SS = D	Continued from page 17 necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to			F0849			08/22/2026

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F0849 SS = D	Continued from page 18 coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure there was a communication process between the long-term care (LTC) facility and the hospice provider to ensure the needs of the resident were met for 1 of 1 resident (R6) reviewed for hospice services. Findings include: R6's quarterly Minimum Data Set (MDS) assessment, dated 6/12/26, indicated R6 was cognitively intact and received hospice services. The "High-Risk Drug			F0849			08/22/2026

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F0849 SS = D	Continued from page 19 Classes: Use and indication” section of the MDS indicated R6 received antipsychotic medications (medications used to treat mood disorders). R6’s diagnoses list included dementia with agitation, stroke, mood disturbances, depression, palliative care, and mental/behavioral disorders R6’s care plan indicated R6 was on hospice and had history of anxiety, agitation, and verbal outbursts. R6’s care plan does not indicate R6 received antipsychotics. R6’s hospice “residential communication form” dated 3/11/26 indicated R6 was started on Seroquel per hospice provider recommendation. The communication form, signed by the hospice nurse, indicated the director of nursing and another staff member were updated on the new order. An order from hospice dated 3/11/26 indicated to start Seroquel 25 mg at bedtime and as needed for behaviors. R6’s monthly “Hospice IDG [Interdisciplinary Group] Comprehensive Assessment and Plan of Care Update Report” , located in the facility hospice binder, dated from 3/26 to 7/26 indicated R6 received Seroquel at bedtime and as needed. R6’s medication administration record (MAR) from 3/26-7/26 did not indicate R6 received antipsychotic medications. During an interview on 7/21/26 at 2:20 p.m., the director of nursing (DON) stated R6 was receiving Seroquel (antipsychotic medication). The DON stated she remembered entering the medication into the record herself. The DON reviewed the current MAR and confirmed the MAR showed no record R6 received antipsychotic medications. The DON reviewed the hospice plan of care update reports in R6’s hospice binder and confirmed Seroquel is listed as a current medication. During an interview on 7/21/26 at 3:01 p.m., R6’s hospice nurse confirmed an order was written 3/11/26 for Seroquel 25 mg at bedtime and as needed and thought the facility providers must have discontinued it. RN-A stated she spoke with the hospice medical provider who confirmed R6 should still be receiving Seroquel. During interview on 7/21/26 at 3:22 p.m., the facility’s physician’s assistant (PA) stated on 6/16/26 there is documentation from clinic staff			F0849			08/22/2026

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F0849 SS = D	Continued from page 20 indicating R6's medication list was reconciled with the hospice medication list. The PA stated she was unable to find documentation the Seroquel was discontinued by their staff and the medication is still active in their system. During an interview on 7/21/26 at 4:30 p.m. the DON stated they do not always review the hospice IDG care plan update notes. The DON confirmed Seroquel is listed on R6's IDG care plan notes in the binder located in the facility. During an interview on 7/21/26 at 4:37 p.m., hospice nurse stated hospice nurses will try to talk to available facility staff for updates during the visits, however the IDG care plan update notes are not specifically discussed with facility staff. A policy titled "Hospice Program" dated 8/25 indicated "In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriate based on the individual resident's needs." The list of responsibilities included "administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care.			F0849			08/22/2026
F0851 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility			F0851	Facility successfully submitted 2nd quarter data PBJ 8/14/2026. 1) Per facility policy, the facility will ensure all staffing data entered into the Payroll-Based Journal (PBJ) system is auditable and able to be verified through either payroll, invoices, and or/tied back to a contract.. 2) The facility will utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual. The Administrator, HR Director and Director of Nursing are responsible for verifying accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports. The Business office is responsible for verifying the accuracy of census data and collaborating with MDS (Minimum Data Set) coordinator for any needed corrections.		08/14/2026

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F0851 SS = C	Continued from page 21 (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll during Quarter 2 2026 (January1-March 31), to the Centers for Medicare Services (CMS), according to specification established by CMS. Findings include:			F0851	Continued from page 21 3) After the Business office has verified the reports from the 3rd party company are correct or make any necessary corrections to hours, job codes or facility numbers and if needed request an updated correct file to submit. 4) The Executive Director or designee will then submit according to the guidelines CMS has put forth currently and making sure that it is correct format in the correct program for accurate submission. 5) The Executive Director or designee will correctly upload the file and submit all manual submissions for agency staff and all other contract employees that have been in part of the direct care staffing. Verifying that upload was accepted by running the PBJ validation report then making any corrections needed. 6) To confirm acceptance of correctness of submission. The Executive Director or designee will then need to run the PBJ final validation report to confirm corrections needed are done and that submission is now correct. 7) Final Report should be run before submission end date to ensure all information is accurate and verified. Run the PBJ individua Daily Staffing report for records of submission done correctly.		08/14/2026

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F0851 SS = C	Continued from page 22 Review of the Payroll Based Journal (PBJ) Casper Report 1705D for quarter 2 2026 (January 1-March 31) identified the facility had one star staffing, 4 or more days within the quarter with no Registered Nurse (RN) hours (35 of 90 days), 4 or more days within the quarter with <24 hours/day licensed nurse coverage (66 of 90 days) , and excessively low weekend staffing. During a joint interview on 7/21/26 at 9:00 a.m., with the facility administrator and administrative assistant, the administrator stated the facility receives a payroll report from a 3rd party payroll agency and the administrative assistant submits the information to CMS. The administrative assistant stated she receives the report from the 3rd party payroll company, logs into the PBJ system, and uploads the report. The facility did not review the information on the report. The administrator and administrative assistant felt the PBJ might have triggered due to how the report was printed from the payroll company which caused issues with transmitting the information to CMS. On 7/21/26 at 9:20 a.m., email communication was sent to the facility's contact person at the payroll management company to discuss PBJ submission data. Multiple attempts to discuss the payroll submission data were made however could not be arranged. During interview on 7/21/26 at 11:09 a.m., the director of nursing pulled payroll and scheduling information for a sample of triggered dates during Quarter 2 2026. The facility verified sufficient staffing on those dates therefore, the data submitted in the payroll-based journal (PBJ) report to the Center for Medicare and Medicaid Services (CMS) was inaccurate. During an interview on 7/21/26 at 11:59 a.m., the administrator stated he was unable to determine if the PBJ triggered due to inaccuracy of information or issues with transmitting information. A policy titled "Payroll Based Journal" revised 7/21/26 indicated "It is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS." "The facility will ensure all staffing data entered in the PayrollBased Journal (PBJ) system is auditable and able to be verified through either payroll, invoices, and or/tied back to			F0851			08/14/2026

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F0851 SS = C	Continued from page 23 a contract". "The facility will utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual". "The administrator, HR director and Director of Nursing are responsible for verifying accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports". The Business Office Manager is responsible for verifying the accuracy of census data and collaborating with MDS [Minimum Data Set] coordinator for any needed corrections. Reports available through CASPER may be utilized to assist with verifying data. "MCHS CFO is responsible for submitting data and obtaining validation reports." "the administrator is responsible for reviewing validation reports and ensuring that any needed corrections are made before the quarterly deadline."			F0851			08/14/2026

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E0000	Initial Comments On 7/19/26-7/21/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			08/17/2026
F0000	INITIAL COMMENTS On 7/19/26-7/21/26, a standard recertification survey (S#) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55363378C (iQIES # 3030134), H55363379C (iQIES # 3027002), H55363380C (iQIES # 2987161) . NO deficiencies were cited. The following complaints were reviewed: H55362966C (iQIES #3046840) with deficiencies cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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			F0000			

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

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F0000	Continued from page 1 has been attained.			F0000			08/17/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement necessary interventions and provided adequate supervision consistent with the person-centered care plan for 1of 1 resident (R14) reviewed. This deficient practice resulted in actual harm when R14 was left unattended in a shower chair, lost balance, fell to the floor, and sustained a forehead laceration requiring eight sutures and an acute subdural hemorrhage (brain bleed). The noncompliance that began on 6/17/26 was corrected prior to the start of survey when the facility implemented a corrective action plan on 6/22/26. This is issued at past noncompliance. Findings include: Review of R14’s Quarterly Minimum Data Set (MDS) assessment, dated 6/10/26 revealed R14 was cognitively intact with no symptoms of delirium and no behavioral expressions. The MDS indicated R14 had limited range of motion in both lower extremities, utilized a wheelchair, was dependent on staff for transfers to/from bed and showers, and was dependent on staff for personal hygiene, bathing, and showering. Review of R14's diagnoses list revealed active diagnoses of Multiple Sclerosis (a disorder affecting muscle movement and control), osteoporosis (a condition causing increased risk of bone fractures), muscle weakness, and unsteady gait. R14’s care plan indicated R14 had a self-care performance deficit related to limited mobility. R14 required assistance by 1 staff for bathing and showering, 2 assist to reposition in bed, and 1 assist			F0689	"Past Noncompliance - no plan of correction required"		08/17/2026

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NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 , MABEL, Minnesota, 55954			
(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
F0689 SS = G	Continued from page 2 for dressing. The care plan also indicated R14 required 1 assist for personal hygiene and was dependent on 2 staff for transfers to and from bed/chair. The care plan was updated 6/17/26 to include R14 was not to be left unattended in the shower. R14's fall risk assessment dated 6/8/26 indicated R14 was at a moderate risk for falls. Review of a facility Incident Progress Note dated 6/17/26 revealed R14 sustained an unwitnessed fall in the shower room, resulting in emergency medical services (EMS) transfer to the emergency room. The note indicated R14 reported she leaned forward and lost her balance. R14 was found on the floor with a laceration to the left forehead, bruising to the left outer shoulder, bruising to the left outer hip, and an abrasion to the left knee. Review of the facility's Root-Cause Analysis (RCA) Report dated 6/17/26 revealed R14 was at risk for falls due to impaired mobility and was left alone in the shower chair. Under environmental factors, the report noted "water running over resident, soap being used for hygiene." Under functional status, the report noted "impaired mobility due to disease process and progression." Review of R14's Hospital Discharge Summary and Neurosurgery Consultation Report dated 6/17/26 revealed R14 sustained head trauma, a left-sided facial laceration, and tenderness to the left outer elbow. Diagnostic imaging revealed an acute right-sided minimal subdural hemorrhage (brain bleed). R14 received eight (8) sutures to repair the forehead laceration and was returned to the facility with monitoring parameters. Review of the facility's post-hospitalization Physician Progress Notes dated 6/22/26 revealed R14 was taking a shower unsupervised on 6/17/26 "because staff were providing privacy." The physician documented: "the plan to prevent this from happening again is for the staff to always remain with [R14] in the bathroom and give her more closer supervision." Interview on 7/20/26 at 11:53 a.m. with NA-B verified that post-incident staff training was effective. NA-B stated she reviews the care plan/Kardex before performing care, received recent shower education, and understands that no resident is ever to be left unattended in the shower room. NA-B stated that any resident requests for solitary showering must be routed through therapy and the			F0689			08/17/2026

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F0689 SS = G	Continued from page 3 charge nurse for safety evaluation. Interview on 7/20/26 at 12:00 p.m. with Occupational Therapist (OT)-A revealed that R14 requires a mechanical lift for all transfers due to severe physical deficits. OT-A stated that a resident's safety to be left alone in a shower depends on both cognition and core abdominal trunk strength. OT-A confirmed that R14 had never been formally assessed by therapy for safety or independent trunk control while seated in the shower chair. Interview on 7/20/26 at 12:38 p.m. with Nursing Assistant (NA)-A revealed that on 6/17/26, she took R14 to the shower room, set her up in the shower chair, and left the room unattended to change the resident's bed linens. NA-A stated that within minutes, she heard a noise and found R14 on the floor bleeding from her head. NA-A stated it had been "customary practice" to leave R14 unattended in the shower room for years because R14 was alert and requested privacy, and that staff checked on her every couple of minutes. NA-A confirmed she knew R14's care plan required an assist of one for showering, but she did not know management was unaware of this custom. Interview on 7/20/26 at 1:13 p.m. with R14 revealed she has always had staff leave her unattended in the shower room during her 4-5 years at the facility. R14 stated that on 6/17/26, "nanoseconds" after the staff member exited the room, she closed her eyes to wash, lost her balance, and fell out of the chair. R14 stated that due to her Multiple Sclerosis, she loses her balance and becomes unstable whenever she closes her eyes. Interview on 7/20/26 at 1:25 p.m. with Registered Nurse (RN)-A revealed she was across the hall when she was alerted R14 was on the floor. R14 was lying on her left side with her arm under her head. R14 had a 1.5-centimeter laceration to her forehead and bruising to the left shoulder, hip, and knee. RN-A stated R14 has a movement disorder affecting her balance and mobility. RN-A stated R14 leaned too far forward, and her legs were not enough to provide a counterbalance causing her to fall. RN-A confirmed R14 is a 1 assist for bathing so facility policy would indicate staff be present during showering; however, it has always been R14's preference to be left unattended. Interview on 7/20/26 at 1:56 p.m. with the Director of Nursing (DON) confirmed she was notified on 6/17/26 that R14 was left alone in the shower and			F0689			08/17/2026

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F0689 SS = G	Continued from page 4 sustained a fall requiring hospital evaluation. The DON confirmed R14 sustained a small brain bleed and a laceration. The DON stated residents should never be left alone in the shower and confirmed R14's care plan indicated 1 assist for bathing. The DON stated she would expect at least 1 staff member to stay with residents in the shower for supervision and assist with showering as the resident needs. A policy titled "Care plans, comprehensive person-centered" dated 3/26 included development of a care plan however did not mention staff expectation for following a resident's care plan. Actions taken included, staff training following the fall included review of bathing and shower/tub policy and procedure as well as care plan, comprehensive person-centered policy and procedure. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.			F0689			08/17/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.			F0578	R22 POLST dated 10/7/25 has been removed with the resident on 8/17/2026 and remains current (CPR Full Code). Other documentation prior to the most recent POLST form of 10/725 has been removed from the facility POLST binder and has be archived into the resident's record. All current residents in the facility will be audited to ensure the resident's advance directives (POLSTS) are accurately and consistency documented in the resident's electronic health record banner, and physician orders to ensure the resident's wishes would be followed in the event of a cardiac arrest. This audit will be completed by date of compliance. Advance Directive policy and procedure was reviewed and updated on 8/14/2026. Facility updated the admission/readmission clinical checklist to ensure the admitting nurse is completing/reviewing the resident's code status with the resident or resident representative upon admission/readmission and ensures the POLST matches the electronic medical record. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following:		08/22/2026

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F0578 SS = D	Continued from page 5 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's advance directives were accurately and consistently documented in the resident's electronic health record (EHR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the resident's wishes would be followed in the event of a cardiac arrest for 1 of 16 residents (R22) reviewed for code status. Findings include: During interview on 7/19/26 at 4:26 p.m., R22 stated the facility did discuss code status with him “a long time ago.” R22 confirmed in the event his heart stopped, or he stopped breathing he would want full CPR. R22’s Minimum Data Set (MDS) assessment, dated 6/5/26, indicated R22 was cognitively intact with no delirium and no behaviors. R22’s form titled “Advanced Directives” dated 5/23/24 indicated “no code”. R22’s readmission hospital discharge summary dated 10/7/25 indicated “full code”. R22’s most recent Provider Orders for Scope of Treatment (POST) dated 10/7/25 indicated “full code”. R22’s April 2026 Electronic Medication Administration Record (EMAR) indicated on the banner at the top of the screen cardiopulmonary resuscitation (CPR)- full code. R22’s May 2026 readmission hospital discharge summary dated 5/14/26 indicated “full code”			F0578	Continued from page 5 1) All nurses who complete admissions/readmissions will be educated on the facility Advance Directives, including the updated admission readmission checklist to ensure the code status is reviewed, and reflects in medical the electronic medical record by date of compliance. Education on policy was initiated on 8/17/2026. All licensed nurses will be educated on the facility policy Advance Directives. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2) The Director of Nursing or designee will complete audits on 5 random residents weekly, including all new admissions/readmissions for 3 months to ensure their advance directives are accurately and consistently documented in the resident's electronic health record banner, Provider Order for Life-Sustaining Treatment (POLST), facility POLST binder, and physician orders Audits will be on-going until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.		08/22/2026

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F0578 SS = D	Continued from page 6 R22's facility signed provider orders 6/16/26 indicated "no code" as of 5/15/26. R22's July 2026 EMAR banner indicated do not resuscitate (DNR)-No code. During an interview on 7/19/26 at 4:36 p.m., licensed practical nurse (LPN)-A stated if a resident was found without signs of life, she would check code status on the banner in the electronic medical record (EMR). If she questioned the code status, she would check the binder containing the POSTs. LPN-A confirmed the EMR banner indicated R22 was a "no code" and, if found with no signs of life, she would not initiate CPR. LPN-A checked the binder and found an advanced directive for R22 that indicated "no code." LPN-A confirmed that date of the advanced directive was dated 5/23/24. In a different sleeve of the binder, LPN-A found a POST for R22, dated 10/7/25, that indicated full code. LPN-A confirmed the discrepancy and stated it needed to be clarified. LPN-A stated based on R22's current banner she would not have needed to check the binder and would not have initiated CPR for R22. During an interview on 7/19/26 at 4:40 p.m., trained medication aide (TMA)-A stated she would check the banner in the Electronic Medical Record (EMR) for code status and would only check the binder if the code status needed to be confirmed. During an interview on 7/19/26 at 5:40 p.m., the director of nursing (DON) stated if a resident is found unresponsive or with no signs of life, she would "go to the orders" to check code status and have someone grab the POST. The DON stated based on R22's current orders, she would not initiate CPR for R22. The DON then checked the treating clinic portal and R22's primary clinic portal to verify code status. The DON confirmed both clinic portals indicate R22 should be a full code. The DON then changed R22's code status from "no code" to "full code". The DON stated facility staff have limited access to clinic portals however she is always available if there are questions regarding code status. The DON stated the admitting nurse is responsible for verifying code status via admitting paperwork and discussion with the resident and/or responsible party. During a follow-up interview on 7/20/26 at 9:00 a.m., the DON stated R22 was hospitalized in May of 2026 . The DON confirmed R22 was a full code at the time of his hospitalization. On 5/15/26 R22			F0578			08/22/2026

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F0578 SS = D	Continued from page 7 returned to the facility. The DON stated R22 returned with a hospital discharge summary, hospital AVS, and an advanced directive form. The director of nursing stated she changed R22's code status based on the advanced directive for that indicated "no code". The DON reviewed the 5/15/26 discharge summary and AVS and confirmed both indicated R22 was "full code". The DON reviewed the advanced directive form and confirmed it was dated 5/23/24. The DON stated she could not recall if she reviewed the AVS or discharge summary. When asked how hospital orders are verified correctly in the EMR, the DON stated after the admitting nurse should review the entire AVS and enter the orders. The AVS is placed in a basket that directs a second nurse to verify them. The second nurse then signs the orders indicating they were verified. The DON also stated she did not confirm with R22 his code status wishes when she changed to "full code" on 7/19/26. Care conference notes dated 6/9/26 section 1b titled "Current Advanced Directives" indicated "full code" During interview on 7/20/26 at 9:19 a.m., the social services designee (SS)-A stated code status is verified during care conferences. The SS-A confirmed R22's care conference notes dating 6/9/26 indicated R22 was a full code. SS-A stated she verifies the resident's wishes during care conferences by asking them, "if your heart were to stop would you like staff to perform CPR" and puts the response in the care conference notes. SS-A stated she does nothing more with that information. If there was question regarding code status, SS-A stated she believed "nursing staff change it and contact the medical doctor." During a follow-up interview on 7/20/26 at 9:43 a.m., the DON confirmed she was present at R22's care conference on 6/9/26, however does not recall what was discussed regarding code status. The DON verified R22's care conference notes dated 6/9/26 indicated "full code" however "nothing is done with that information unless there is concern." When asked to confirm the admission/readmission process, the DON stated once the admitting nurse enters the orders, they are considered "live". The verifying nurse just compares the AVS and the orders entered and signs the AVS. The DON confirmed R22's hospital AVS dated 5/15/26 did not have a verification signature. During an interview on 7/20/26 at 10:00 a.m., the facility medical director (MD) stated code status must be confirmed when a resident is admitted or readmitted from an acute care facility. If a POST was			F0578			08/22/2026

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F0578 SS = D	Continued from page 8 previously completed, it must be verified with the resident or responsible party. If a discrepancy is found on an advanced directive the facility must verify that with the resident or responsible party and also notify the provider. A policy titled "Advanced Directives" dated 11/2025 defined "advanced directives" as a written instruction, recognized by state law relating to the provisions of health care when the individual is incapacitated. "Do not resuscitate (DNR) indicates, in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy or representative has directed that no cardiopulmonary resuscitation (CPR) or life sustaining treatments or methods are to be used. POST is defined as a form designed to improve patient care by creating a portable medical order form that records the resident's treatment wishes so emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the resident's current medical condition into consideration" The policy also indicated if the resident has an advanced directive, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any staff. The director of nursing or designee notifies the attending physician of advanced directives, or changes in advance directives, that the appropriate orders can be documented in the resident's medical record and plan of care. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advanced directive document in a prominent, accessible location in the medical record and discussing the residents' wishes in care planning meetings. The plan of care for each resident is consistent with their documented treatment preferences and or advanced directive. The interdisciplinary team will review annually with the residents their advance directives to ensure such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The nurse supervisor is required to inform emergency medical personnel of a resident's advanced directives regarding treatment options and provide such personnel with a copy of the advanced directive or POST when transferring from the facility via ambulance or other means.			F0578			08/22/2026

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F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			F0628	R32's discharge on 5/1/2026 will be reported to Ombudsman on 8/19/2026. All residents who have been discharged from the skilled nursing facility or had a transfer to acute care from 7/9/25 to 8/19/2026 will be reported to Ombudsman by date of compliance. Policy, Notification of Ombudsman for Long Term Care, Acute Care Transfers, and Discharge Notification was created on 8/14/2026. Risk of Reoccurrence Administrator of Designee initiating the following: 1) Social service designee will be educated on facility policy, Notification of Ombudsman for Long Term Care, Acute Care Transfers, and Discharge Notification on 8/19/2026. Education included documenting all acute care transfers and discharges on facility log and will be sent to Ombudsman monthly per policy. 2) The administrator will complete audit once monthly that discharge or acute care transfer log was completed and communicated to the MN Office of Ombudsman per policy for three months. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need further auditing and/or additional staff training.		08/22/2026

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F0628 SS = D	Continued from page 10 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the			F0628			08/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/21/2026	
NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 , MABEL, Minnesota, 55954			
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F0628 SS = D	Continued from page 11 mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with			F0628			08/22/2026

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F0628 SS = D	Continued from page 12 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Ombudsman of the discharge for 1 of 1 resident (R32) reviewed. This practice had the potential to affect all residents who transferred or discharged from September 2025 to July 2026 reviewed for Ombudsman notification. Findings Include R32 record reviewed discharged 5/1/26. R32's record lacked ombudsman notification. During an interview on 07/20/26 3:30 p.m., social service designee (SSD) revealed unaware of the facility ombudsman notification process as SSD was new in the role. On 07/21/2026 6:14p.m., SSD and administrator			F0628			08/22/2026

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F0628 SS = D	Continued from page 13 provided a binder containing logs titled "Monthly Notice to MN Ombudsman for Long Term care of Emergency Acute Care Transfer and Discharge ". The logs were reviewed and indicated, last notification to the Ombudsman was sent on by facsimile was on July 9th, 2025. The facility policy for transfer and discharge was requested and not received.			F0628			08/22/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility			F0641	The MDS coordinator corrected the resident's assessment coding, as indicated by record review and facility review, to ensure the medication use was accurately reflected. The MDS coordinator compared active medication orders against recent MDS assessments for all residents who may have antipsychotic use. Any resident found to have incomplete or inaccurate coding was corrected immediately. Resident care plans were reviewed and care current for antipsychotic use. The MDS coordinator established a standardized pre-submission review checklist for medication-related items. The MDS coordinator will audit 100% of assessments involving antipsychotic medications weekly for the first 30 days. After the initial 30 days, audits will be completed monthly until QAPI deems audits meet substantial compliance. MDS Coordinator - primary responsibility for accurate assessment coding and chart review. Immediate correction for R6: completed upon identification of the deficiency. 8/14/2026. 100% resident chart antipsychotic medication MDS accuracy review: Completed 8/14/26.		08/14/2026

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F0641 SS = D	Continued from page 14 failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R6) reviewed for antipsychotic medication use. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2025, identified Section N: Medications to be completed with an intent to record the number of days, during the last 7 days that select medications were received by the resident to include antipsychotic medications. The manual further indicated, "Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications". Further, the manual provided several coding instructions, including directing staff to "check if an antipsychotic medication was taken by the resident at any time during the 7 day look-back period (or since admission/entry or reentry if less than 17 days)". It also directs staff to "check if there is an indication noted for all antipsychotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days)". The "Antipsychotic medication Review" section directs staff to indicate if the resident received antipsychotic medications since admission/entry or reentry or the prior assessment by answering yes or no. R6's quarterly MDS assessment dated 6/12/26 indicated R6 was cognitively intact. The MDS indicated R6 received antipsychotic medications during the previous 7 days. however the "Antipsychotic medication review" section indicated R7 had not received antipsychotic medications. R6's medication administration record (MAR) dated 6/2026 showed no record R6 received antipsychotic medications during the month. During an interview on 7/21/26 at 3:37 p.m., the facility MDS nurse stated she would "typically" look at the residents MAR to determine medications taken during the observed 7 days of the assessment. If the MAR shows a resident was administered certain medications, she will code it as such on the MDS. The MDS nurse reviewed R6's MAR and confirmed R6 did not receive antipsychotic medications during the observed time. The MDS nurse reviewed R6's quarterly MDS dated 6/12/26 and confirmed she did indicate R6 received antipsychotic medications and			F0641			08/14/2026

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F0641 SS = D	Continued from page 15 there were indications for the administration of the medication. The MDS nurse then reviewed the "antipsychotic medication review" section of the MDS and confirmed she indicated R6 did not receive antipsychotic medications. The MDs nurse stated R6's MDS was one of the first ones she did for the facility and she must have marked "yes" by mistake. During an interview on 7/21/26 at 6:00 p.m., the director of nursing indicated MDS accuracy is important for coordination of residents' care and proper reimbursements rates for the facility. A policy titled "Certifying Accuracy of the Resident Assessment" dated 11/2025 indicated "the information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment." "Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment."			F0641			08/14/2026
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the			F0849	R6 Seroquel medication order prescribed by hospice was initiated per physician orders on 7/22/26. R6"s medication list will be reconciled against the most recent hospice IDG (intradisciplinary group) comprehensive assessment plan of care report. Policy, Hospice Program reviewed and updated on 8/14/2026. The facility has communicated with hospice agencies utilized in the facility that they provide the DON or designee or licensed nurse on duty after hours order-changes or plan of care updates for the resident. It will be the practice going forward that the items will be dated and signed by the licensed nurse who processes the physician orders/plan of care changes. All current residents who receive hospice services will have an audit completed to ensure most recent orders have been implemented by the facility by date of compliance.		08/22/2026

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F0849 SS = D	Continued from page 16 hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are			F0849	Continued from page 16 Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All licensed nurses will be educated on Hospice Program policy and procedures by date of compliance. Education includes reviewing and completing new order changes per hospice plan of care by date of compliance. Education of the policy was initiated on 8/17/26. All on call license nurses who have not worked prior to compliance date will be educated prior to their next scheduled shift. 2) The DON or designee will audit 3 random residents receiving hospice services for three months to ensure order changes or plan of care updates are implemented. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.		08/22/2026

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F0849 SS = D	Continued from page 17 necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to			F0849			08/22/2026

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F0849 SS = D	Continued from page 18 coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure there was a communication process between the long-term care (LTC) facility and the hospice provider to ensure the needs of the resident were met for 1 of 1 resident (R6) reviewed for hospice services. Findings include: R6's quarterly Minimum Data Set (MDS) assessment, dated 6/12/26, indicated R6 was cognitively intact and received hospice services. The "High-Risk Drug			F0849			08/22/2026

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F0849 SS = D	Continued from page 19 Classes: Use and indication” section of the MDS indicated R6 received antipsychotic medications (medications used to treat mood disorders). R6’s diagnoses list included dementia with agitation, stroke, mood disturbances, depression, palliative care, and mental/behavioral disorders R6’s care plan indicated R6 was on hospice and had history of anxiety, agitation, and verbal outbursts. R6’s care plan does not indicate R6 received antipsychotics. R6’s hospice “residential communication form” dated 3/11/26 indicated R6 was started on Seroquel per hospice provider recommendation. The communication form, signed by the hospice nurse, indicated the director of nursing and another staff member were updated on the new order. An order from hospice dated 3/11/26 indicated to start Seroquel 25 mg at bedtime and as needed for behaviors. R6’s monthly “Hospice IDG [Interdisciplinary Group] Comprehensive Assessment and Plan of Care Update Report” , located in the facility hospice binder, dated from 3/26 to 7/26 indicated R6 received Seroquel at bedtime and as needed. R6’s medication administration record (MAR) from 3/26-7/26 did not indicate R6 received antipsychotic medications. During an interview on 7/21/26 at 2:20 p.m., the director of nursing (DON) stated R6 was receiving Seroquel (antipsychotic medication). The DON stated she remembered entering the medication into the record herself. The DON reviewed the current MAR and confirmed the MAR showed no record R6 received antipsychotic medications. The DON reviewed the hospice plan of care update reports in R6’s hospice binder and confirmed Seroquel is listed as a current medication. During an interview on 7/21/26 at 3:01 p.m., R6’s hospice nurse confirmed an order was written 3/11/26 for Seroquel 25 mg at bedtime and as needed and thought the facility providers must have discontinued it. RN-A stated she spoke with the hospice medical provider who confirmed R6 should still be receiving Seroquel. During interview on 7/21/26 at 3:22 p.m., the facility’s physician’s assistant (PA) stated on 6/16/26 there is documentation from clinic staff			F0849			08/22/2026

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F0849 SS = D	Continued from page 20 indicating R6's medication list was reconciled with the hospice medication list. The PA stated she was unable to find documentation the Seroquel was discontinued by their staff and the medication is still active in their system. During an interview on 7/21/26 at 4:30 p.m. the DON stated they do not always review the hospice IDG care plan update notes. The DON confirmed Seroquel is listed on R6's IDG care plan notes in the binder located in the facility. During an interview on 7/21/26 at 4:37 p.m., hospice nurse stated hospice nurses will try to talk to available facility staff for updates during the visits, however the IDG care plan update notes are not specifically discussed with facility staff. A policy titled "Hospice Program" dated 8/25 indicated "In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriate based on the individual resident's needs." The list of responsibilities included "administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care.			F0849			08/22/2026
F0851 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility			F0851	Facility successfully submitted 2nd quarter data PBJ 8/14/2026. 1) Per facility policy, the facility will ensure all staffing data entered into the Payroll-Based Journal (PBJ) system is auditable and able to be verified through either payroll, invoices, and or/tied back to a contract.. 2) The facility will utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual. The Administrator, HR Director and Director of Nursing are responsible for verifying accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports. The Business office is responsible for verifying the accuracy of census data and collaborating with MDS (Minimum Data Set) coordinator for any needed corrections.		08/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/21/2026	
NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 , MABEL, Minnesota, 55954			
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F0851 SS = C	Continued from page 21 (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll during Quarter 2 2026 (January1-March 31), to the Centers for Medicare Services (CMS), according to specification established by CMS. Findings include:			F0851	Continued from page 21 3) After the Business office has verified the reports from the 3rd party company are correct or make any necessary corrections to hours, job codes or facility numbers and if needed request an updated correct file to submit. 4) The Executive Director or designee will then submit according to the guidelines CMS has put forth currently and making sure that it is correct format in the correct program for accurate submission. 5) The Executive Director or designee will correctly upload the file and submit all manual submissions for agency staff and all other contract employees that have been in part of the direct care staffing. Verifying that upload was accepted by running the PBJ validation report then making any corrections needed. 6) To confirm acceptance of correctness of submission. The Executive Director or designee will then need to run the PBJ final validation report to confirm corrections needed are done and that submission is now correct. 7) Final Report should be run before submission end date to ensure all information is accurate and verified. Run the PBJ individua Daily Staffing report for records of submission done correctly.		08/14/2026

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F0851 SS = C	Continued from page 22 Review of the Payroll Based Journal (PBJ) Casper Report 1705D for quarter 2 2026 (January 1-March 31) identified the facility had one star staffing, 4 or more days within the quarter with no Registered Nurse (RN) hours (35 of 90 days), 4 or more days within the quarter with <24 hours/day licensed nurse coverage (66 of 90 days) , and excessively low weekend staffing. During a joint interview on 7/21/26 at 9:00 a.m., with the facility administrator and administrative assistant, the administrator stated the facility receives a payroll report from a 3rd party payroll agency and the administrative assistant submits the information to CMS. The administrative assistant stated she receives the report from the 3rd party payroll company, logs into the PBJ system, and uploads the report. The facility did not review the information on the report. The administrator and administrative assistant felt the PBJ might have triggered due to how the report was printed from the payroll company which caused issues with transmitting the information to CMS. On 7/21/26 at 9:20 a.m., email communication was sent to the facility's contact person at the payroll management company to discuss PBJ submission data. Multiple attempts to discuss the payroll submission data were made however could not be arranged. During interview on 7/21/26 at 11:09 a.m., the director of nursing pulled payroll and scheduling information for a sample of triggered dates during Quarter 2 2026. The facility verified sufficient staffing on those dates therefore, the data submitted in the payroll-based journal (PBJ) report to the Center for Medicare and Medicaid Services (CMS) was inaccurate. During an interview on 7/21/26 at 11:59 a.m., the administrator stated he was unable to determine if the PBJ triggered due to inaccuracy of information or issues with transmitting information. A policy titled "Payroll Based Journal" revised 7/21/26 indicated "It is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS." "The facility will ensure all staffing data entered in the PayrollBased Journal (PBJ) system is auditable and able to be verified through either payroll, invoices, and or/tied back to			F0851			08/14/2026

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F0851 SS = C	Continued from page 23 a contract". "The facility will utilize the current submission guidelines as described in the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual". "The administrator, HR director and Director of Nursing are responsible for verifying accuracy of the staffing data that is submitted to CMS using various facility audit forms and/or payroll vendor reports". The Business Office Manager is responsible for verifying the accuracy of census data and collaborating with MDS [Minimum Data Set] coordinator for any needed corrections. Reports available through CASPER may be utilized to assist with verifying data. "MCHS CFO is responsible for submitting data and obtaining validation reports." "the administrator is responsible for reviewing validation reports and ensuring that any needed corrections are made before the quarterly deadline."			F0851			08/14/2026