



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 22, 2025

Administrator
Green Lea Senior Living
115 NORTH LYNDAL, RR 2 BOX 49
MABEL, MN 55954

RE: CCN: 245536

Cycle Start Date: June 5, 2025

Dear Administrator:

On July 11, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

I free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Electronically delivered

August 22, 2025

Administrator

Green Lea Senior Living

115 NORTH LYNDAL, RR 2 BOX 49

MABEL, MN 55954

Re: Reinspection Results

Event ID: 9IX611

Dear Administrator:

On July 11, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 5, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2025

Administrator
Green Lea Senior Living
115 North Lyndale, Rr 2 Box 49
Mabel, MN 55954

RE: CCN: 245536
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by September 5, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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Electronically delivered
June 24, 2025

Administrator
Green Lea Senior Living
115 North Lyndale, Rr 2 Box 49
Mabel, MN 55954

Re: State Nursing Home Licensing Orders
Event ID: 9IX611

Dear Administrator:

The above facility was surveyed on June 2, 2025, through June 5, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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

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

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

PO Box 64975 | 625 Robert Street North

St. Paul, MN 55164-0975

Office: 651-201-4384

Email: holly.zahler@state.mn.us

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

PRINTED: 07/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2025	
NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 MABEL, MN 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
F 000	INITIAL COMMENTS On 6/2/25 to 6/5/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. : H55365988C - MN00109316 H55365990C - MN00108134 The following complaints were reviewed. Deficient practice was identified related to incidental finding. H55365989C - MN00102591 H55365991C - MN00102907 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 has been attained.			F 000			
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:			F 557			7/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 557	Continued From page 1 §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to maintain respect and dignity for personal possessions for 1 of 2 residents (R28) reviewed who had his room searched and items removed without consent. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 4/10/25 included no cognitive impairment. Furthermore, his mood assessment indicated he rarely socially isolated. R28 is independent with eating, oral hygiene, toileting, dressing, and repositioning. R28 required minimal cueing for showering/bathing. During interview on 6/03/25 at 11:20 a.m., R28 stated the previous administrator at the facility entered his room without his permission and searched his room, the administrator told him they were searching his room because they thought he was making moonshine with orange peels and water or mouthwash. They also confiscated his vape pens and won't give them back. R28 added the administrator came into his room without consent and removed multiple cups and dishes. R28 said he felt he can't trust anyone here because they come in whenever they want, and he feels socially isolated since they searched his room.	F 557	The facility will ensure that resident's private space and property are respected at all times; staff do not handle or move a resident's personal belongings without the resident's permission. Facility Dignity Policy was reviewed and updated on 06/27/25 Risk of re-occurrence will be minimized by the Executive Director or designee initiating the following: 1) All staff will be educated on the facility policy in regards to dignity by compliance date. Education included: knocking before entering a resident's room, respecting resident's space and property at all times, not removing personal belongings without the resident's permission. Education on the policy was initiated 06/27/25. 2) Executive Director or designee will complete audits on 2 random residents weekly for 3 months to ensure dignity is respected per facility policy. 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. Date of completion: July 5, 2025		

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

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F 557	Continued From page 2 During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R28 has not been treated respectfully. CNA-A stated the previous administration had entered and searched his room without his permission. CNA-A stated the administrator believed he was using his orange peels to make moonshine. CNA-A stated the administrator believed he also had illegal substances in his room. CNA-A confirmed law enforcement was not at the facility at any point. CNA-A stated the previous administrator had confiscated his vape pens. During interview on 6/5/25 at 4:06 p.m., director of nursing (DON) and administrator stated it was possible the previous administrator had entered and searched R28's room without his consent. The DON and administrator confirmed they were not at the facility at the time of the search. The administrator confirmed a note in the chart on 3/12/25 at 10:40 a.m., indicated the resident's room had been search without his consent. The administrator confirmed a note in the chart on 3/11/25 at 3:18 p.m., indicated facility staff had entered the resident's room without permission to remove facility property. The DON confirmed entering R28's room without permission could have a negative impact on his social well-being. Per facility policy titled Dignity and dated February 2021, facility staff must knock and request permission before entering a residents' room. Residents' private space and property are respected at all times; staff do not handle or move a resident's personal belongings without the resident's permission.	F 557			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561			7/5/25

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F 561	Continued From page 3 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate bathing/showering preferences for 1 of 1 resident (R1) reviewed for choices. Finding include: R1's admission Minimum Data Set (MDS)			F 561	R1 care plan has been updated to ensure his bathing preferences have been met. Care Plans- Baseline Policy and Procedure was reviewed and updated on 6/25/2025. All current residents in the facility were		

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F 561	Continued From page 4 assessment dated 5/6/25 identified admission to the facility on 4/30/25, had intact cognition. R1 required substantial/maximal assistance from facility staff for shower/bathing. R1's care plan dated 5/7/25 contained only one item; R1 had a potential nutritional deficit related to Parkinson's, dementia, chronic pain and depression. The care plan lacked personal preference for showering/bathing preferences. During observation and interview on 6/3/25 at 11:05 a.m., R1 stated he preferred to have showers/baths on Monday, Wednesday, and Friday (M/W/F). R1 stated he rarely gets 3 showers/baths as he prefers; usually getting showers/baths 2 days per week; Tuesdays and Fridays. During interview on 6/4/25 at 10:34 a.m., R1 stated he told the facility when he was admitted he preferred showering/bathing on M/W/F; was assured by facility staff this request could be accommodated. R1's treatment administration record (TAR) dated May 2025 showed showering/bathing was completed on the following dates: -Tuesday, 5/6/25 -Friday, 5/9/25 -Tuesday, 5/13/25 -Friday, 5/16/25 -Tuesday, 5/20/25 -Saturday, 5/24/25 -Friday, 5/30/25 -Tuesday, 6/3/25 During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R1's			F 561	audited to ensure their bathing preferences are met. Admission nurse is assessing resident upon admission on bathing preferences and ensuring the bath schedule is updated to reflect resident requests. 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 the facility policy Care Plans- Baseline by compliance date. Education included: ensuring resident preferences on bathing schedules are assessed, care planned and followed through on per facility policy. Education on the policy was initiated on 5/26/25. 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 will complete audits on 3 random residents weekly for 3 months to ensure personal preferences on bathing schedule are completed per facility policy. 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. Date of completion: July 5, 2025		

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F 561	Continued From page 5 showering/bathing schedule was Tuesdays and Fridays. CNA-A stated the assistant director of nursing (ADON) or the director of nursing (DON) completed the resident preferences on admission; however, with the change in leadership she is unsure who completed resident preferences for R1. During interview on 6/05/2025 at 11:47 a.m., ADON stated the (DON) does the admission care plan. ADON stated a baseline care plan is done with admission assessments to include resident name, code status, primary diagnosis, continence, skin, activities of daily living (adl's); the baseline care plan should contain resident preferences for showering/bathing schedule. ADON confirmed R1 did not have a comprehensive care plan. Per facility policy titled Care Plans-Baseline dated March 2022; a baseline (temporary) Care Plan to meet the resident's immediate health and safety needs is developed for each resident during the first shift of admission. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment.	F 561			
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the	F 568			7/5/25

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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, MN 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
F 568	Continued From page 6 resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident's trust account statements were provided on, at least, a quarterly basis. The lack of provided statements had the potential to affect all residents with trust accounts at the care center. During the recertification survey from 6/2/25 to 6/5/25, a facility complaint regarding access to funds was investigated. An incidental finding during this investigation revealed the facility was not sending quarterly statements to residents or resident representatives. During interview on 6/3/25 at 24:45 p.m., business office manager (BOM) stated the facility does not send out quarterly statements. During interview on 6/4/25 at 8:57 a.m., administrator confirmed the facility does not send out quarterly statements. An undated facility policy titled Accounting and Records of Resident funds; individual accounting records are made available to the resident through quarterly statements and upon request.	F 568	The facility will ensure that individual accounting records are made available to the resident through quarterly statements and upon request. The facility policy Accounting and Records of Resident funds was reviewed and updated 06/24/25 and quarterly statements was sent out to residents and/or their representatives in regards to their trust fund accounts. Risk of re-occurrence will be minimized by the Executive Director and/or designee initiating the following: 1) Business Office Manager and Social Services were educated on the facility policy Accounting and Records of Resident Funds 06/24/25. Education included individual accounting records are made available to the resident through quarterly statements and upon request. 2) Business Office Manager and/or designee will complete audits quarterly that statements were sent out in regards to the resident trust fund accounts. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) BOM has set calendar alerts to ensure		

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F 568	Continued From page 7	F 568	quarterly statements are sent to resident and/or POA.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656	4) Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training	7/5/25	

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F 656	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a person-centered care plan for 2 of 2 residents (R19, R1) reviewed for care planning. Findings include: R19 R19's admission Minimum Data Set (MDS) assessment dated 5/5/25 indicated R19 was cognitively intact with no behaviors. R19 had limited range of motion to one lower extremity, supervision with eating and oral cares, partial moderate assistance for toileting hygiene and bathing and lower body dressing, and supervision with bed mobility. The MDS indicated R19 was frequently incontinent of urine and bowel and had multiple medical conditions including: atrial fibrillation (abnormal rhythm of the heart), heart failure, hypertension (high blood pressure), peripheral vascular disease (impaired blood flow	F 656	R19 discharged from the facility on 6/4/25. R1 had a person-centered comprehensive care plan completed on 6/26/25. Policy and procedure, Care Plans, Comprehensive Person-Centered, was reviewed and updated on 6/25/25. The facility implemented the MDS schedule sent out at a minimum of monthly to include the date in which the comprehensive care plan is due. All current residents who have been in the facility for 21 days will be audited to ensure a person-centered comprehensive care plan has been completed. Risk of re-occurrence will be minimized by the Director of Nursing or designee		

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F 656	Continued From page 9 to extremities), renal insufficiency (impaired kidney function), diabetes, anxiety, and schizophrenia (mental health diagnosis), R19's admission MDS also indicated R19 had a history of falls prior to admission. The MDS indicated R19 received insulin injections (medication to treat elevated blood sugar), antipsychotic (medication to treat mental health disorders, antidepressant (medication to treat depression and other mental health disorders), anticoagulant (medication used to prevent blood clots), and diuretic (medication used to treat fluid accumulation). Care areas triggered included communication, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and psychotropic drug use. The care areas triggered were documented "addressed on care plan". R19's care plans included "dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognition and needing reminders of scheduled activities" dated 5/19/25, "Resident to be discharged to alternative living facility/community" dated 5/23/25, "advanced directive-[R19] has chosen the code status of full code" dated 5/23/25, "potential nutrition problem" dated 5/7/25, and "potential impairment to skin integrity ..." dated 5/12/25. R19's record lacked a person-centered comprehensive care plan. R19's "temporary care plan" (care plan given to nursing assistants) included admitting diagnoses, diet, assist for cares, continence, oral care, skin			F 656	initiating the following: 1) DON, ADON, MDS Coordinator, and all department managers responsible for completing the care planning process will be educated on facility policy, Care Plans, Comprehensive Person-Centered, prior to our compliance date. Education on the policy was initiated on 6/26/25. Education included: ensuring residents have a person-centered comprehensive care plan completed no more than 21 days after admission and per policy. 2) 5 random residents will be audited weekly for 3 months to ensure the resident has a person-centered comprehensive care plan completed per the policy. 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. Date of completion: July 5, 2025		

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F 656	Continued From page 10 issues, and therapy orders. R19's physician orders included amlodipine, losartan, spironolactone, and metoprolol for hypertension, Eliquis for atrial fibrillation, furosemide for congestive heart failure, olanzapine for schizophrenia, and aspart insulin injections for diabetes. During an interview on 6/5/25 at 10:12 a.m., LPN-A stated R19 admitted to the facility for rehab services, kept to himself, and had no behaviors. LPN-A stated the director of nursing (DON), assistant director of nursing (ADON), or MDS coordinator enter in care plans at admission. R1 R1's admission Minimum Data Set (MDS) assessment dated 5/6/25 identified admission to the facility on 4/30/25, R1 was cognitively intact with no behaviors. The MDS indicated R1 had a functional impairment of both the left upper and left lower limbs. R1's MDS also indicated R1 needed partial to moderate assistance with eating and oral hygiene. Further, R1 was dependent on facility staff for toileting, dressing, and mobility. R1 was frequently incontinent of bowel and had an indwelling catheter to drain his bladder. The care areas triggered were communication, activities of daily living, indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain management. The care areas triggered were documented "addressed on care plan". R1's admission diagnosis included, Parkinson's	F 656			

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F 656	Continued From page 11 disease (movement disorder of the nervous system that worsens over time), dementia (general decline in cognitive ability that affect a person's ability to perform everyday activities), high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1's care plan dated 5/7/25 contained only one item; R1 had a potential nutritional deficit related to Parkinson's, dementia, chronic pain and depression. The care plan lacked areas triggered on the MDS assessment. At the time of the re-certification survey from 6/2/25 to 6/5/25, R1's comprehensive care plan had not been completed. During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R1's showering/bathing schedule was Tuesdays and Fridays. CNA-A stated the assistant director of nursing (ADON) or the director of nursing (DON) completed the resident preferences on admission; however, with the change in leadership she is unsure who completed resident preferences for R1. During interview on 6/5/25 at 11:47 a.m., the ADON stated admission assessments and reconciliation of provider orders is performed by her or the DON. The comprehensive care plans are entered by the DON. A baseline care plan is implemented immediately upon admission that consists of a resident's name, code status, admitting diagnoses, continence, skin, and instructions for ADL's. A copy of the baseline care plan is located at the nursing assistant station. The comprehensive care plan is developed over a period after admission. The			F 656			

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F 656	Continued From page 12 ADON confirmed R19 and R1 did not have a comprehensive care plan.			F 656			
F 727 SS=F	A facility policy titled Care Plans-Baseline dated March 2022, staff conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(b)(4)(C)(i);483.35(c)(1)-(3) Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an			F 727			7/5/25

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F 727	Continued From page 13 average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the services of a registered nurse (RN) onsite for 8 consecutive hours/7 days a week. This had the potential to affect all residents who resided at the facility. Findings include: The payroll based journal (PBJ) staffing report for quarter 2 of 2025 (January 1-March 31) indicated no RN hours reported for the following days : 1/02 (TH), 1/03 (FR), 1/04 (SA), 1/05 (SU), 1/09 (TH), 1/18 (SA), 1/19 (SU), 2/02 (SU), 2/16 (SU), 3/1 (SA), 3/02 (SU), 3/15 (SA), 3/16 (SU), 3/29 (SA), 3/30 (SU). Review of facility payroll and staffing schedules indicated 4 hours of RN coverage on 1/4/2025 and no RN coverage for 1/05, 1/18, 1/19, 2/02, 2/16, 3/01, 3/02, 3/15, 3/16, 3/29, and 3/30. During interview on 6/3/25 at approximately 3 p.m., the regional nurse consultant confirmed there was no RN coverage for the indicated dates and confirmed it is an expectation to have an RN in the building 8 consecutive hours a day/ 7 days a week. During an interview on 6/5/25 at 12:17 p.m., the assistant director of nursing (ADON) stated the staffing coordinator is responsible for nursing schedules. The ADON stated there has been no issue with services not being provided due to not having an RN on duty for 8 consecutive hours. During an interview on 6/5/25 at 3:15 p.m., the	F 727	The facility will ensure a registered nurse is scheduled for 8 consecutive hours every 24 hours, seven days a week. The facility process was updated to include the staffing coordinator who will update the Director of Nursing if an RN is not scheduled on a specific day, to ensure the Director of Nursing or RN designee is on site to cover as the 8 hours consecutive RN coverage for the day. RN was hired on 05/01/25 and the facility now has an RN hired and scheduled for a minimum of 8 consecutive hours a day/7days a week. The facility continues to recruit, job post, and hire RNs for the facility. Staffing, Sufficient and Competent Nursing Policy and Procedure was reviewed and updated on 6/25/2025. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Staffing Coordinator, Director of Nursing and Assistant Director of Nursing will be educated on the facility policy Staffing, Sufficient and Competent Nursing by compliance date. Education included: ensuring a Registered Nurse is scheduled 8 consecutive hours every 24 hours, seven days a week. Education on the policy was initiated on 6/26/25. 2) The Director of Nursing will complete 1-time weekly audit for the weeks daily		

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F 727	Continued From page 14 staffing coordinator indicated there are two staff RNs who work at the facility. One RN works full time on the overnight shift, the other recently started and works evenings. The staffing coordinator confirmed struggling to have RN coverage every other weekend. A policy titled "Staffing, sufficient and competent Nursing" dated April 2025 line 3 indicated "A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the residents and based on the facility assessment."	F 727	staffing to ensure an RN has been scheduled and worked 8 consecutive hours every 24 hours. 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 the findings and need for further auditing and/or additional staff training. Date of completion: July 5, 2025		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/03/2025. At the time of this survey, GREEN LEA SENIOR LIVING was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GREEN LEA SENIOR LIVING is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1961, with additions following in 1969, and 1989. All to be determined as Type II (111). The original building has a partial basement, and all additions have no basement. There is an assisted living facility which is separated from the nursing home			K 000			

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K 000	Continued From page 2 by a 2-hour fire separation. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 41 beds and had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with			K 324			7/7/25

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER GREEN LEA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 MABEL, MN 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
K 324	Continued From page 3 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 06/03/2025 at 11:30 AM, it was revealed by observation that the residential stove-range located in the Activities Area was not outfitted with a 120 minute maximum timeout / controller device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324			
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of	K 346	Stove was unplugged by Maintenance Director 06/03/25 McKabe Electric ordered 120 minute maximum timeout/controller device on 06/04/25 Time-out Controller will be installed according to McKabe Electric during the week of 07/07/25		6/4/25

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K 346	Continued From page 4 services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 4.6.1, 9.6.1.6. This deficient finding a widespread impact on the residents within the facility. Findings include: On 06/03/2025 between 10:30 AM and 1:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy was a template policy. The document reviewed had incorrect callouts and references to AHJ's in Iowa. The document reviewed did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 346	The template policy was updated with the correct callouts and references on 06/04/25. by the Executive Director Policy will be reviewed annually by the Executive Director and/or designee		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,			K 353			6/4/25

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K 353	Continued From page 5 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 11:35 AM, it was revealed by observation that sprinkler head(s) protecting the commercial stove / range top exhibited signs of debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 353	Olympic Fire cleaned debris from sprinkler heads on 06/04/25 Semi-annual inspection by Olympic Fire was completed on 06/04/25 Sprinkler heads will be audited monthly by Maintenance Director		
K 354 SS=C	Sprinkler System - Out of Service			K 354			6/4/25

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K 354	Continued From page 6 CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding a widespread impact on the residents within the facility. Findings include: On 06/03/2025 between 10:30 AM and 1:30 PM, it was revealed by a review of available documentation that the sprinkler system out-of-service policy was a template policy. The document reviewed had incorrect callouts and references to AHJ's in Iowa. The document reviewed did not include in the notification listing the MN Department of Public Safety - Fire	K 354	The policy was updated on 06/04/25 with the appropriate callouts and references for Green Lea Senior Living by the Executive Director. Policy will be audited annually by Executive Director and/or designee.		

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K 354	Continued From page 7 Marshal Division (point of contact and phone #).			K 354			
K 374 SS=F	An interview with the Maintenance Director verified this deficient finding at the time of discovery. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/03/2025 at 11:40 AM, it was revealed by observation that smoke barrier door assembly for Wing 100 exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke.			K 374	Vertical Brush Sweeps were ordered from Direct Supply 06/04/25 Direct Supply called Maintenance Director 06/30/25 and stated that Vertical Brush Strips to be delivered within 15 days or less Maintenance Director will place Pemko Strips on doors by 07/01/25 until Vertical Brush Sweeps arrive. Doors will be audited during facility fire drills by Maintenance Director.		7/1/25

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K 374	Continued From page 8	K 374			
K 541 SS=D	2. On 06/03/2025 at 11:45 AM, it was revealed by observation that smoke barrier door assembly for Wing 200 exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery. Rubbish Chutes, Incinerators, and Laundry Chutes CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 541			6/25/25

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K 541	Continued From page 9 Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 11:50 AM, it was revealed by observation that linen chute intake door assembly did not close, latch, and seal the vertical shaft opening upon test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	Maintenance Director replaced cylinder on linen chute on 06/25/25 Linen chute will be audited quarterly by Maintenance Director		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced	K 711		6/30/25	

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K 711	Continued From page 10 by: Based on a review of available documentation and staff interview, the facility failed to maintain their Emergency Plan per NFPA 101 (2012 edition), Life Safety Code, section(s) 4.8, 19.7, 19.7.1, 19.7.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 between 10:30 AM and 1:30 PM, a review of available documentation revealed that multiple independent documents were presented for review - associated to the Emergency Plans & Procedures for the facility. All documents presented had key and appropriate content, however it was unclear as to which policy(s) / procedure(s) would be implemented in the event of an emergency. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 711	06/30/25 Policies were reviewed and implemented correct policies for the Emergency Plan and Procedures by the Executive Director and Maintenance Director Emergency Plan and Procedures Binder will be reviewed annually by Executive Director and Maintenance.		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		7/1/25	

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K 761	Continued From page 11 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.4.3.9, 8.3.3. and NFPA 80 (2010 edition), sections 5.2.4.2.(5), 6.3.1.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 at 11:50 AM, it was revealed by observation that that the Dining Room fire door assembly exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	Vertical Brush Sweeps were ordered from Direct Supply 06/04/25 Direct Supply called Maintenance Director 06/30/25 and stated that Vertical Brush Strips to be delivered within 15 days or less Maintenance Director will place Pemko Strips on doors by 07/01/25 until Vertical Brush Sweeps arrive. Doors will be audited during facility fire drills by Maintenance Director.		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/2/25-6/5/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and		2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/27/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with NO deficiencies cited. H55365988C - MN00109316 H55365990C - MN00108134 The following complaints were reviewed. Deficient practice was identified related to incidental finding. H55365989C - MN00102591 H55365991C - MN00102907 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000			

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to develop a person-centered care plan for 2 of 2 residents (R19, R1) reviewed for care planning. Findings include: R19 R19's admission Minimum Data Set (MDS) assessment dated 5/5/25 indicated R19 was cognitively intact with no behaviors. R19 had	2 565	R19 discharged from the facility on 6/4/25. R1 had a person-centered comprehensive care plan completed on 6/26/25. Policy and procedure, Care Plans, Comprehensive Person-Centered, was reviewed and updated on 6/25/25. The facility implemented the MDS schedule sent out at a minimum of monthly to include the date in which the		7/5/25

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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, MN 55954		
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2 565	Continued From page 3 limited range of motion to one lower extremity, supervision with eating and oral cares, partial moderate assistance for toileting hygiene and bathing and lower body dressing, and supervision with bed mobility. The MDS indicated R19 was frequently incontinent of urine and bowel and had multiple medical conditions including: atrial fibrillation (abnormal rhythm of the heart), heart failure, hypertension (high blood pressure), peripheral vascular disease (impaired blood flow to extremities), renal insufficiency (impaired kidney function), diabetes, anxiety, and schizophrenia (mental health diagnosis), R19's admission MDS also indicated R19 had a history of falls prior to admission. The MDS indicated R19 received insulin injections (medication to treat elevated blood sugar), antipsychotic (medication to treat mental health disorders, antidepressant (medication to treat depression and other mental health disorders), anticoagulant (medication used to prevent blood clots), and diuretic (medication used to treat fluid accumulation). Care areas triggered included communication, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and psychotropic drug use. The care areas triggered were documented "addressed on care plan". R19's care plans included "dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognition and needing reminders of scheduled activities" dated 5/19/25, "Resident to be discharged to alternative living facility/community" dated 5/23/25, "advanced directive-[R19] has chosen the code status of full code" dated 5/23/25, "potential nutrition problem"	2 565	comprehensive care plan is due. All current residents who have been in the facility for 21 days will be audited to ensure a person-centered comprehensive care plan has been completed. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) DON, ADON, MDS Coordinator, and all department managers responsible for completing the care planning process will be educated on facility policy, Care Plans, Comprehensive Person-Centered, prior to our compliance date. Education on the policy was initiated on 6/26/25. Education included: ensuring residents have a person-centered comprehensive care plan completed no more than 21 days after admission and per policy. 2) 5 random residents will be audited weekly for 3 months to ensure the resident has a person-centered comprehensive care plan completed per the policy. 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. Date of completion: July 5, 2025		

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2 565	Continued From page 4 dated 5/7/25, and "potential impairment to skin integrity ..." dated 5/12/25. R19's record lacked a person-centered comprehensive care plan. R19's "temporary care plan" (care plan given to nursing assistants) included admitting diagnoses, diet, assist for cares, continence, oral care, skin issues, and therapy orders. R19's physician orders included amlodipine, losartan, spironolactone, and metoprolol for hypertension, Eliquis for atrial fibrillation, furosemide for congestive heart failure, olanzapine for schizophrenia, and aspart insulin injections for diabetes. During an interview on 6/5/25 at 10:12 a.m., LPN-A stated R19 admitted to the facility for rehab services, kept to himself, and had no behaviors. LPN-A stated the director of nursing (DON), assistant director of nursing (ADON), or MDS coordinator enter in care plans at admission. R1 R1's admission Minimum Data Set (MDS) assessment dated 5/6/25 identified admission to the facility on 4/30/25, R1 was cognitively intact with no behaviors. The MDS indicated R1 had a functional impairment of both the left upper and left lower limbs. R1's MDS also indicated R1 needed partial to moderate assistance with eating and oral hygiene. Further, R1 was dependent on facility staff for toileting, dressing, and mobility. R1 was frequently incontinent of bowel and had an indwelling catheter to drain his bladder. The care areas triggered were communication, activities of daily living, indwelling catheter,	2 565			

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2 565	Continued From page 5 psychosocial well-being, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain management. The care areas triggered were documented "addressed on care plan". R1's admission diagnosis included, Parkinson's disease (movement disorder of the nervous system that worsens over time), dementia (general decline in cognitive ability that affect a person's ability to perform everyday activities), high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1's care plan dated 5/7/25 contained only one item; R1 had a potential nutritional deficit related to Parkinson's, dementia, chronic pain and depression. The care plan lacked areas triggered on the MDS assessment. At the time of the re-certification survey from 6/2/25 to 6/5/25, R1's comprehensive care plan had not been completed. During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R1's showering/bathing schedule was Tuesdays and Fridays. CNA-A stated the assistant director of nursing (ADON) or the director of nursing (DON) completed the resident preferences on admission; however, with the change in leadership she is unsure who completed resident preferences for R1. During interview on 6/5/25 at 11:47 a.m., the ADON stated admission assessments and reconciliation of provider orders is performed by her or the DON. The comprehensive care plans are entered by the DON. A baseline care plan is implemented immediately upon admission that	2 565			

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2 565	Continued From page 6 consists of a resident's name, code status, admitting diagnoses, continence, skin, and instructions for ADL's. A copy of the baseline care plan is located at the nursing assistant station. The comprehensive care plan is developed over a period after admission. The ADON confirmed R19 and R1 did not have a comprehensive care plan. A facility policy titled Care Plans-Baseline dated March 2022, staff conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical	21665			7/5/25

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21665	Continued From page 7 environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the facility failed to maintain respect and dignity for personal possessions for 1 of 2 residents (R28) reviewed who had his room searched and items removed without consent. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 4/10/25 included no cognitive impairment. Furthermore, his mood assessment indicated he rarely socially isolated. R28 is independent with eating, oral hygiene, toileting, dressing, and repositioning. R28 required minimal cueing for showering/bathing. During interview on 6/03/25 at 11:20 a.m., R28 stated the previous administrator at the facility entered his room without his permission and searched his room, the administrator told him they were searching his room because they thought he was making moonshine with orange peels and water or mouthwash. They also confiscated his vape pens and won't give them back. R28 added the administrator came into his room without consent and removed multiple cups and dishes. R28 said he felt he can't trust anyone here because they come in whenever they want, and he feels socially isolated since they searched his room. During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R28 has not been treated respectfully. CNA-A stated	21665	Corrected		

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21665	Continued From page 8 the previous administration had entered and searched his room without his permission. CNA-A stated the administrator believed he was using his orange peels to make moonshine. CNA-A stated the administrator believed he also had illegal substances in his room. CNA-A confirmed law enforcement was not at the facility at any point. CNA-A stated the previous administrator had confiscated his vape pens. During interview on 6/5/25 at 4:06 p.m., director of nursing (DON) and administrator stated it was possible the previous administrator had entered and searched R28's room without his consent. The DON and administrator confirmed they were not at the facility at the time of the search. The administrator confirmed a note in the chart on 3/12/25 at 10:40 a.m., indicated the resident's room had been search without his consent. The administrator confirmed a note in the chart on 3/11/25 at 3:18 p.m., indicated facility staff had entered the resident's room without permission to remove facility property. The DON confirmed entering R28's room without permission could have a negative impact on his social well-being. Per facility policy titled Dignity and dated February 2021, facility staff must knock and request permission before entering a residents' room. Residents' private space and property are respected at all times; staff do not handle or move a resident's personal belongings without the resident's permission. SUGGESTED METHOD OF CORRECTION:The DON or designee, could educate staff regarding the resident's rights to have their personal possessions and staff do not conduct search of residents' room or person without consent. The DON or designee, could educate staff regarding	21665			

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21665	Continued From page 9 illegal substance that pose a risk to resident and in plain view, the facility may remove; if illegal substances are suspected, the facility needs to call law enforcement. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665			
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After	21830			7/5/25

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21830	Continued From page 10 notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the	21830			

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21830	Continued From page 11 admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate bathing/showering preferences for 1 of 1 resident (R1) reviewed for choices. Finding include: R1's admission Minimum Data Set (MDS) assessment dated 5/6/25 identified admission to the facility on 4/30/25, had intact cognition. R1 required substantial/maximal assistance from facility staff for shower/bathing. R1's care plan dated 5/7/25 contained only one item; R1 had a potential nutritional deficit related to Parkinson's, dementia, chronic pain and depression. The care plan lacked personal preference for showering/bathing preferences.	21830	R1 care plan has been updated to ensure his bathing preferences have been met. Care Plans- Baseline Policy and Procedure was reviewed and updated on 6/25/2025. All current residents in the facility were audited to ensure their bathing preferences are met. Admission nurse is assessing resident upon admission on bathing preferences and ensuring the bath schedule is updated to reflect resident requests. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following:		

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21830	Continued From page 12 During observation and interview on 6/3/25 at 11:05 a.m., R1 stated he preferred to have showers/baths on Monday, Wednesday, and Friday (M/W/F). R1 stated he rarely gets 3 showers/baths as he prefers; usually getting showers/baths 2 days per week; Tuesdays and Fridays. During interview on 6/4/25 at 10:34 a.m., R1 stated he told the facility when he was admitted he preferred showering/bathing on M/W/F; was assured by facility staff this request could be accommodated. R1's treatment administration record (TAR) dated May 2025 showed showering/bathing was completed on the following dates: -Tuesday, 5/6/25 -Friday, 5/9/25 -Tuesday, 5/13/25 -Friday, 5/16/25 -Tuesday, 5/20/25 -Saturday, 5/24/25 -Friday, 5/30/25 -Tuesday, 6/3/25 During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R1's showering/bathing schedule was Tuesdays and Fridays. CNA-A stated the assistant director of nursing (ADON) or the director of nursing (DON) completed the resident preferences on admission; however, with the change in leadership she is unsure who completed resident preferences for R1. During interview on 6/05/2025 at 11:47 a.m., ADON stated the (DON) does the admission care plan. ADON stated a baseline care plan is done with admission assessments to include resident	21830	1) All licensed nurses will be educated on the facility policy Care Plans- Baseline by compliance date. Education included: ensuring resident preferences on bathing schedules are assessed, care planned and followed through on per facility policy. Education on the policy was initiated on 5/26/25. 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 will complete audits on 3 random residents weekly for 3 months to ensure personal preferences on bathing schedule are completed per facility policy. 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. Date of completion: July 5, 2025		

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21830	Continued From page 13 name, code status, primary diagnosis, continence, skin, activities of daily living (adl's); the baseline care plan should contain resident preferences for showering/bathing schedule. ADON confirmed R1 did not have a comprehensive care plan. Per facility policy titled Care Plans-Baseline dated March 2022; a baseline (temporary) Care Plan to meet the resident's immediate health and safety needs is developed for each resident during the first shift of admission. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830			