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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GROF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245536**

2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN LEA SENIOR LIVING**
(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/21/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **41** (L18)

13.Total Certified Beds **41** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 10/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/27/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/13/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/04/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 27, 2021

CMS Certification Number (CCN): 245536

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 30, 2021 the above facility is certified for:

41 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 41 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 27, 2021

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

RE: CCN: 245536
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 27, 2021, we notified you a remedy was imposed. On October 21, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 30, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 11, 2021 be discontinued as of September 30, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 27, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 5, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

October 27, 2021

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

RE: Project Number

Dear Administrator:

On October 25, 2021, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $0 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on October 21, 2021 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $0. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $168.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $168.20 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GROF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245536**

2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN LEA SENIOR LIVING**
(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/21/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **41** (L18)

13.Total Certified Beds **41** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
April Rovang Johnson, HFE NE II 10/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/25/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/13/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/04/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered on *October 25, 2021*

October 25, 2021

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

Re: Project #

Dear Administrator:

On September 21, 2021, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 5, 2021 with orders received by you on October 25, 2021.

State licensing orders issued pursuant to the last survey completed on August 5, 2021, found not corrected at the time of this September 21, 2021 revisit and subject to penalty assessment are as follows:

21426 -- MN St. Statute 144A.04 Subd. 3 -- Tuberculosis Prevention And Control---$0

The details of the violations noted at the time of this revisit completed on September 21, 2021 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $0 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us

Office: (651) 201-3794 Mobile: (320) 249-2805

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Program Assurance Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GROF

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Facility ID: 00124

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(L1) **245536**

2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

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(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

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1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/05/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **41** (L18)

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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
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__ 7. Medical Director
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__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 09/17/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/01/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
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06/13/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
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24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
August 27, 2021

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

RE: CCN: 245536
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 5, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 4, 2021, the situation of immediate jeopardy to potential health and safety cited at F0678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 11, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 11, 2021, (42 CFR 488.417 (b)). They will also notify the State

Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 11, 2021, (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Green Lea Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 5, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 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 February 5, 2022 (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 DENIAL OF PAYMENT

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) 565-9462

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal

Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	**115 NORTH LYNDALE, 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
E 000	Initial Comments On 8/2/21-8/5/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6)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	E 000		
F 000	INITIAL COMMENTS On 8/2/21 through 8/5/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5536008C (MN00074134) and H5536009C (MN00055606). The survey resulted in an Immediate Jeopardy (IJ) at F678. The IJ was identified and began on 7/22/21, and the administrator and director of nursing (DON) were notified of the immediate jeopardy at 9:50 a.m. on 8/4/21. The IJ was removed on 8/5/21, but noncompliance remained at the lower scope and severity level of D, isolated with the potential to cause more than minimal harm. The above findings constituted substandard	F 000		

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

Electronically Signed | 09/03/2021

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F 000	Continued From page 1 quality of care and an extended survey was conducted 8/4/21-8/5/21. 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 that substantial compliance with the regulations has been attained.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for receiving, transcribing and communicating code status orders for cardiopulmonary resuscitation (CPR) for 1 of 12 residents (R228) reviewed for advanced directives and wishes for life sustaining treatment. This failure resulted in an immediate jeopardy (IJ) when it was identified R228 had conflicting advanced directives and could result in a resident's wishes not being honored as stated in their code status orders. This failure had the potential to effect any resident having	F 678	PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	9/8/21

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F 678	Continued From page 2 their code status reviewed upon admission, quarterly or as needed. The immediate jeopardy began on 7/22/21 when conflicting code status orders were identified in R228's medical record and a lack of clarity in the process for attaining, transcribing, signing and communicating physician code status orders was confirmed. The facility administrator and DON were notified of the immediate jeopardy at 9:50 a.m. on 8/4/21. The IJ was removed on 8/5/21, but noncompliance remained at the lower scope and severity level of D, isolated with the potential to cause more than minimal harm. Findings include: R228's admission Minimum Data Set assessment dated 7/26/21 indicated R228 had no behaviors, intake cognition and could make self known and could understand others. According to R228's Admission Record in the electronic health record (EHR), R228 was admitted to the facility 7/20/21 following a total knee replacement. According to the Physician Orders list in R228's EHR, an order of "Full Code" (perform CPR in the case of cardiac arrest) had been transcribed into the record on 7/21/21, but indicated the order had been "verified by medical record only" (was not a written or verbal order from a physician). According to a hard copy record in R228's medical chart titled Physician's Orders for Life-Sustaining Treatment (POLST) and dated 7/22/21, indicated R228 wished to have a Do Not	F 678	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 678 Cardio-Pulmonary Resuscitation (CPR), Green Lea Senior Living corrected the deficiency by completing an audit on 08/17/2021 and again on 09/02/2021 by the Social Worker for all other residents to ensure the POLST was signed by the resident/family and the MD/NP. R228 was discharged on 9/7/21. The MAR/TAR was updated for each resident and pulls automatically once the order has been entered in PCC. 2. To correct the deficiency and to ensure the problem does not recur staff Nurses were educated on 09/03/2021 by DON. Those not working will be educated prior to the start of their next scheduled shift on the CPR policy by Administrator or DON. The DON and/or designee will review the POLST form upon admission and it will be reviewed quarterly at care conferences. The DON and/or designee will audit weekly x4 weeks, then monthly x3 months to ensure continued compliance. 3. As part of Green Lea Senior Living	

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F 678	Continued From page 3 Resuscitate (DNR) order in the case of cardiac arrest. This form was signed by the facility social worker (SW) and R228 on 7/22/21. On the same date a nurse practitioner signed the form making it an order. On 8/3/21 it was observed that R228's EHR held an electronically scanned form of the POLST signed 7/22/21, but the conflicting Full Code order remained on the Physician Orders list. According to an interview on 8/3/21, at 11:14 a.m. a licensed practical nurse (LPN-A) stated nurses were trained to always go to the POLST for code status orders. According to an interview on 8/3/21, at 11:21 a.m. a registered nurse, RN-A stated there were multiple places to look in a resident ' s chart to find what their code status was, but in the case of conflicting orders she would perform CPR. According to an interview on 8/3/21, at 1:20 p.m. R228 stated she did not recall signing the POLST form, but thought she would like to have CPR done if her heart were to stop. On 8/3/21, R228's medical doctor (MD-A) was observed to be present in the building and visited R228. According to an interview on 8/3/21, at 4:15 p.m. Medical Records staff (MR-A) stated MD-A had signed orders for R228, that day but was no longer in the building. MR-A confirmed no previous printed/signed orders had been present in R228 's chart, and the orders signed on 8/3/21 were R228 's admission orders. MR-A stated	F 678	ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the communities QA Process.	

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F 678	Continued From page 4	F 678		

when a resident is newly admitted to the facility, staff would transcribe orders into their electronic medical record. They would then print the orders and put them on a clipboard for the physician to sign when he/she would next be in the building. MR-A stated she did not know if they were sent over to the physician any sooner for review. The physician Order Summary Report for R228 was observed on MR-A's desk and was dated as having been printed 8/3/21, 8:17 a.m. and was signed by MD-A on 8/3/21. The orders contained the Full Code order originally entered on 7/21/21. MR-A confirmed that this information was observed as being correct.

During further review of R228's medical record on 8/3/21, R228's EHR Physician Orders list, included an order changing R228 from Full Code to DNR/DNI (do not intubate) status, entered by facility SW on 8/3/21 and indicated the order had been verified by "medical record only."

According to an interview on 8/3/21, at 4:28 p.m. the SW stated she had not talked to R228 prior to entering the updated order on 8/3/21, saying, "I had talked to her the day we signed the POLST order." SW said she had not reviewed R228's medical record for any updated physician orders related to code status, and was unaware MD-A had signed a document indicating R228 should be "full code."

During an interview on 8/3/21, at 4:30 p.m. DON stated she was sure the facility had a policy that addressed CPR and expected it would be followed. DON said the variance in orders would be "an easy fix for me."

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F 678	Continued From page 5 According to an phone interview on 8/4/21, 8:47 a.m. MD-A confirmed he had been in the facility and had seen R228 and signed her printed order summary. MD-A stated he had not noticed the summary included a full code order and said, "that was an error on my part;" additionally, MD-A confirmed he had not spoken to R228 about changing her code status. MD-A stated orders pertaining to codes status should be sent to the nurse practitioner upon admission for a signature. A review of the facility CPR policy on 8/3/21 indicated the POLST was the correct place to find a code status; however, the policy failed to include a procedure for who was to obtain the orders, enter the orders into the system or communicate that information to the staff. The immediate jeopardy that began on 7/22/21 was removed on 8/5/21 when it could be verified the facility had implemented an appropriate removal plan including correcting R228's code status to reflect her current wishes; reviewing all other resident charts to ensure they had correct and current POLST's/code status in place; updating the facility POLST/CPR/Advanced Directives Guidelines to clarify that a nurse is responsible to get a signed order for code status upon admission. Additionally, if a resident arrives with a signed POLST order, it must be reviewed and the provider notified of the contents of the POLST, and further assess/address the contents of the POLST with the resident during their 14 day admission assessment period to ensure it continues to reflect the wishes of the resident. The facility initiated training with nursing staff and SW with a plan in place for educating in nursing	F 678		

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F 678	Continued From page 6 staff not in the building that day. The facility will review all POLST documents upon admission, quarterly, significant change, and annually. Additionally, MD-A was advised of the updated process. Facility had a plan to continue to audit the process after each new admission.	F 678		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide and/or arrange proper foot care for 1 of 3 (R11) who requested to see a podiatrist for long toenails. Findings include: During an observation and interview on 8/2/21, at 4:05 p.m. R11 was walking in his room barefoot. R11 had very long toenails; nails were grown past the end of the toes. The toenails of the 3rd toe on both feet were up against the second toes. R11 stated he could not trim his own toenails and he needed to go to the podiatrist. R11 stated the nail on the one toe digs into the toe next to it,	F 687	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 687 Foot Care -Green Lea Senior	9/8/21

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F 687	Continued From page 7 sometimes it would hurt but not right now. R11 indicated staff did not trim his toenails because they were done by the podiatrist. R11's admission Minimum Data Set (MDS) dated 5/20/21, indicated R11 had moderate cognitive impairment and did not have rejection of care behaviors. The MDS identified R11 required extensive assist from one staff for dressing and limited assistance for personal hygiene. The MDS indicated R11 was at risk for pressure ulcers and did not have any skin concerns at the time of assessment. R11's Body Audit dated 6/16/21, included "Toenails are not clean or trimmed at this time." R11's Body Audit dated 6/23/21, included, "Toenails and trimmed at this time. Inspection of feet ankles and toes indicate callous overlapping toes" and indicated "family contacted regarding need to see podiatrist" R11's Body Audit dated 6/30/21, included "Toenails are not clean or trimmed at this time" and Callous overlapping toenail deformities. R11's Body Audit dated 7/7/21, included, "Toenails are not clean or trimmed at this time" and Callous overlapping toenail deformities. R11's Body Audit dated 7/14/21, included, "Toenails are not clean or trimmed at this time. Inspection of feet, ankles and toes indicated they are clearoverlapping [sic] toes" R11's Body Audit dated 7/21/21, included, "Toenails are not clean or trimmed at this time"	F 687	Living corrected the deficiency by scheduling resident #11 a podiatry appointment. Resident #11 went to the podiatrist on 8-17-21. An audit was completed on 8-18-2021 by nursing of all residents to review the need for podiatry with no urgent needs. A podiatry contract was signed on 8-31-21 with Preferred Podiatry Group scheduled to round at the facility on 10/04/2021. 2. To correct the deficiency and to ensure the problem does not recur nurses were educated by the DON 09/02/2021 and 09/03/2021 on the need for podiatry and monitoring residents for the need to be seen. The DON and/or designee will audit the residents need for podiatry services and schedule appointments as needed weekly x4 weeks, then monthly x3 months to ensure continued compliance. 3. As part of Green Lea Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community□s QA Process.	

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F 687	Continued From page 8	F 687		

and inspection identified overlapping toenail deformities."

During an observation on 8/4/21, at 10:10 a.m. R11 stood in his room with bare feet. R11's toenails were the same length as observed on 8/2/21.

During an interview on 8/4/21, at 7:03 a.m. nursing assistant (NA)-A indicated podiatry did not come to the facility; residents had to go to an outside podiatry clinic.

During an interview on 8/4/21, at 8:02 a.m. NA-B stated there was not a podiatrist that had come to the facility at all, stated last week a few residents were taken to the podiatrist. NA-B stated she gave R11 a bath last week and did not cut his toenails because they were "super thick, so I reported to the nurse."

During an interview on 8/4/21, at 10:15 a.m. licensed practical nurse (LPN)-A observed R11's feet, "indicated his toenails were long" LPN-A stated there has been a callous on his one second toe because of the long toenail, however, was not there now. LPN-A indicated she has offered to trim R11's toenails, "he told me he wanted to go to the podiatrist." LPN-A stated nursing could probably cut some of the nails that were not so thick; a physician could cut them. LPN-A indicated it was the facility's responsibility to make appointments and set up the transportation, however the facility was waiting for R11's family to get back to them when it was a good time for them.

During an interview on 8/5/21, licensed social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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F 687	Continued From page 9 worker (LSW) stated she helped make transportation arrangements to dental and vision appointments and could assist with podiatry however had not been asked to. LSW stated R11's family take care of his appointments based on their schedule. LSW indicated, the follow-up should have been completed to ensure R11 had necessary foot care done in a timely manner. Facility did not provide a policy	F 687		
F 689 SS=D	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 observation, interview and document review, the facility failed to comprehensively assess each fall, identify causative factors to determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 1 of 2 residents (R17) reviewed for accidents. Findings include: Minimum Data Set (MDS) completed on 6/11/21, indicated R17 was a one person physical assist with bed mobility, personal hygiene and bathing and a two person physical assist with transfers and toileting. Primary medical condition listed on	F 689	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 689 Free of Hazards/	9/8/21

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F 689	Continued From page 10 MDS was debility and cardiorespiratory conditions. R17's face sheet diagnoses of unspecified psychosis, vascular dementia, anxiety disorder and anoxic (when the body does not get any oxygen) brain damage. R17's Fall Risk Assessment dated 4/3/2021 indicated R17 was at a high fall risk with a score of 80 on the Morse Fall Scale, a method of assessing a resident's likelihood of falling. R17's medical record indicated R17 had sustained 10 falls between 3/9/21 and 8/5/21. R17's care plan included, "Resident has had multiple falls with hx[sic] of major injury (hip fracture)and also minor injuries such as skin tears d/t poor balance, poor comprehension, unaware of safety risks and unsteady gait R/T over all functional and cognitive decline." Interventions included, "Anticipate needs, particularly when he appears anxious or restless but also with each interaction. Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed at appropriate height, Grab bar/U-bar as ordered, Handrails on walls, Personal items within reach. Frequent checks by staff. Offer toileting each time. Provide reminders to wait for assist from staff." Incident report dated 3/9/21 indicated R17 had eloped from the building at 9:45 P.M., where he sustained a fall resulting in a skin tear to left elbow, scrape to left pinky finger and a purple	F 689	Supervision/Devices Green Lea Senior Living corrected the deficiency by reviewing residents with multiple falls in the last 6 months for root cause and interventions by the IDT team. Interventions and care plans were updated accordingly for resident R17 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur staff Nurses, CNAs, and TMA□s were educated on 8-17-21 and again on 09-02-2021 and 09-03-2021 on the fall policy by the DON. The DON and/or designee will audit all falls weekly x4 weeks, then monthly x3 months to ensure continued compliance. 3. As part of Green Lea Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community□s QA Process.	

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F 689	Continued From page 11	F 689		

bruise on left elbow. No immediate intervention was noted on the incident report and a post fall evaluation was not supplied by the facility when requested.

Incident report dated 3/24/21 indicated R17 sustained a fall in his room while standing up attempting to put his belt on. No immediate intervention was noted on the incident report. Post fall data collection form indicated intervention implemented was to educate resident to ask for assistance. Potential root cause was medical status/physical condition/diagnosis and no changes made to care plan.

Incident reported dated 4/12/21 indicated R17 sustained a fall at 3:30 P.M. in the main lobby when standing with his walker. No immediate intervention was noted on the incident report and a post fall data collection was not supplied by the facility when requested.

Incident report dated 4/27/21 indicated R17 was found sitting on the floor in his room at 12:30 A.M. and was unable to say what happened. R17 sustained a skin tear on left elbow. Immediate intervention was R17 was taken to the dining room and given a cup of coffee. No post fall evaluation was supplied by facility when requested.

Incident report dated 5/21/21 indicated R17 was observed in his room kneeling in front of his wheelchair trying to get up at 3:30 P.M. R17 stated he fell from his wheelchair when attempting to pick something up from the floor. R17 sustained a C-shaped laceration on the right

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	245536	A. BUILDING _____ B. WING _____	C 08/05/2021

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F 689	Continued From page 12	F 689		

side of his head that measured 1.5 inches and a skin tear on left wrist measuring 0.5 inches. No immediate interventions were noted in the incident report and no post fall evaluation was supplied by facility when requested.

Incident report dated 5/26/21 indicated R17 was found kneeling on the floor of his room in front of his wheelchair at 3:23 P.M. R17 was incontinent of bowel and sustained a skin tear to his left wrist. Immediate intervention was frequent checks. No post fall evaluation was supplied by facility when requested.

Incident report dated 6/15/21 indicated a staff member was walking by R17's room at 8:15 A.M. and observed him standing in the middle of the room when he lost his balance and fell to the floor. R17 sustained a skin tear to his left elbow and had a small bruise there as well. No immediate intervention was identified on the incident form. Post fall evaluation indicated interventions utilized were to rearrange R17's room, declutter room and keep mobility device at bedside. No changed were made to the care plan.

Incident report dated 6/19/21 indicated R17 was found on the floor in his room at 1:59 P.M. R17 was toileted just prior to the fall and R17 stated he was "trying to get out of here." R17 sustained a skin tear to his left inner elbow measuring 0.5 centimeters. No immediate intervention noted on incident report. Post fall intervention indicated interventions included keeping mobility device at bedside. No changes were made to the care plan.

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F 689	Continued From page 13	F 689		

Incident report dated 7/14/21 indicated R17 was found sitting on the bathroom floor with gripper socks on holding onto a urinal and there was urine on the floor. R17 was placed in bed thirty minutes prior per report. Immediate intervention was to bring R17 out to the lobby. Post fall evaluation indicated no interventions were put into place and no changed were made to the care plan.

Incident report dated 7/15/21 indicated R17 was found on the floor of his room with his back resting against television stand. A glass of water was noted to have been spilled on the floor. Immediate intervention was frequent checks. Post fall evaluation indicated interventions included frequent visual checks and no changes were made to the care plan.

A post fall evaluation dated 7/16/21 indicated R17 was found on the floor of his room at 7:00 P.M. and sustained a bruise and abrasion to the front of right knee. Interventions included self locking brakes to wheelchair and review/adjust toileting schedule. The evaluation did not indicate if the care plan was updated.

During an interview on 8/5/21, at 1:18 p.m., Director of Nursing (DON) was unable to identify an investigation was completed in order to identify the root cause of 7 of 9 falls that occurred on the following dates: 3/9/21, 4/27/21, 5/21/21, 5/26/21, 6/15/21, 6/19/21, 7/14/21. DON was asked if more should have been done to help prevent further falls from occurring and DON stated, "I cannot answer your question because I do not know what they did."

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F 689	Continued From page 14 Facility's fall policy was requested on 8/5/21 and not provided. A policy titled Adverse Event Reports-Electronic Record Completion was supplied which outlined instructions on completing incident reports within the electronic medical record, including but not limited to completing an adverse event form in the electronic medical record that includes details of the incident, injuries, predisposing factors, witnesses if applicable and action taken. The interdisciplinary team (IDT) then completes the note section to include root cause analysis of incident and interventions initiated.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		9/8/21

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F 758	Continued From page 15 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to offer/attempt non-pharmacological interventions prior to administration of as needed (PRN) antipsychotic medication for 1 of 5 (R1) reviewed for unnecessary medications. In addition, the facility failed to ensure as needed (PRN) antipsychotic medications were limited to 14 days unless there was documented physician assessment of justification for continued use for 2 of 5 residents (R17 & R18) reviewed for unnecessary medications.	F 758	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

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F 758	Continued From page 16 Findings include: R1's face sheet dated 8/5/21, included diagnoses of dementia with behavioral disturbance and major depressive disorder. R1's annual Minimum Data Set (MDS) assessment dated 8/4/2021, identified R1 had severe cognitive impairment, had symptoms of delirium. MDS indicated R1 did not have hallucinations/delusion, demonstrated behavior not directed towards other 1 to 3 days, and wandering behaviors one to three days. The MDS indicated those behaviors worsened since the previous assessment. MDS indicated R1 was administered an antidepressant medication and was not administered an antipsychotic. R1's behavioral care plan included the following: -[R1] has exhibit the following behaviors: isolated incidents of verbal and physical abuse toward staff. Three incidents in dining room. Uncertain of trigger in dining room. At this time [R1] has not require medication management (dated 2/10/2020]. Corresponding interventions included; Attempt non-pharmacological interventions and observe effectiveness. Interventions include: 1:1 to attempt to address what is upset about. Reasoning has history of not effective. Enable [R1] to return to his room/his comfort zone and time to calm himself down. Observe behavior and attempt to determine pattern, frequency, intensity and triggers. -[R1] uses antipsychotic medication (dated 2/18/21). Interventions included Observe/record target behaviors/symptoms and document per facility protocol. Non-pharmacological	F 758	1. In continuing compliance with F 758 Free from Unnecessary Psychotropic Meds Green Lea Senior Living corrected the deficiency by auditing for all prn psychotropic medications and having pharmacy complete a medication review and notifying the MD/NP for orders on R1,R17, R18, and all like residents. All nurses were educated on 09-03-2021, or prior to their next shift, on offering 3 nonpharmacological interventions prior to giving a prn medication. On 8-11-2021 R1 had a pharmacy review with no new orders and on 8-18-2021 his prn psychotropic medication was ordered as a scheduled medication. On 8-11-2021 R17 had a pharmacy review, MD ordered to continue prn psychotropic medication. R18 was reviewed for prn psychotropic medication on 08-11-2021 and R18 does not have any prn psychotropic medication ordered. 2. To correct the deficiency and to ensure the problem does not recur nurses were educated on 8-17-2021 and again on 09-02-2021 and 09-03/2021 on prn psychotropic medications requiring a 14 day stop date or the MD/NP documenting their rationale and indicating the duration of the prn medication by DON. The consultant pharmacist will continue his monthly medication review and make recommendations as appropriate. The DON and/or designee will audit all prn psychotropic medications weekly x4 weeks, then monthly x3 months to ensure	

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	245536	A. BUILDING _____ B. WING _____	C 08/05/2021

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F 758	Continued From page 17 interventions included: 1:1 conversation, distraction, ask R1 to help with a specific task, therapy has a peg board that R1 enjoys putting colored pegs into. R1 loves coffee-offer coffee and a cookie and observe effectiveness. -[R1] has episodes of inattention, disorganized thinking related to dementia, psychosis and depression (dated 4/20/21). Corresponding interventions included approach in calm voice, with only one person if possible. R1's physician orders included haloperidol (antipsychotic medication) 2 mg (milligrams) as needed for agitation (with harm to self or others) as needed (PRN) three times a day related to psychosis not due to substance or known physiological condition. R1's Point of Care (POC- nursing assistant documentation) behavior documentation was reviewed from 7/7/21 to 8/4/21; documentation identified behaviors were documented once of shift with check marked boxes identifying which behaviors R1 exhibited during that shift. The documentation did not identify how many occurrences during that shift R1 exhibited the specified behavior nor any documentation of non-pharmacological interventions that were offered or attempted to manage the behavior. Behaviors that were identified included, constant walking/pacing, sexually inappropriate behaviors, distressing delusions/hallucinations (speaking to/yelling at individuals), rejection of care, threatening, screaming, cursing at others, biting scratching, grabbing others, striking out hitting or kicking, disruptive sounds/screaming, and wandering.	F 758	continued compliance. 3. As part of Green Lea Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community□s QA Process.	

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F 758	Continued From page 18 R1's July and August Medication Administration Record (MAR) in conjunction with progress notes were reviewed. PRN haloperidol was administered on the following dates: MAR on 7/2/21 at 8:19 p.m. R1 was administered haloperidol. Progress note indicated a behavior was observed (did not include what behavior). MAR on 7/8/21 at 7:46 p.m. haloperidol was administered. Progress note indicated a behavior was observed (did not include what behavior). Progress note 7/13/21, at 6:40 a.m. indicated R1 was irritable and yelling, "I have to go now!" MAR at 8:45 a.m. haloperidol was administered, progress note indicated a behavior was observed. Progress note at 10:23 a.m. indicated the administration was not effective and R1 continued to holler out at staff. MAR at 7:29 p.m. indicated haloperidol was administered, progress note included, R1 "agitated wheeling around talking about Nazis". MAR on 7/15/21, at 7:00 p.m. haloperidol was administered. Progress note included, "yelling that his recliner chair is moving (chair was sitting stationary). States "the only thing I want is to get the hell out of this place." MAR on 7/16/21, at 5:43 p.m. haloperidol was administered. Progress note included "resident has increased agitation: yelling, screaming, kicking, in and out of the room. Taken to the bathroom which he had a [large bowel movement] on the toilet, administered medication and now sitting in the recliner." MAR on 7/17/21, at 12:08 a.m. haloperidol was administered. Progress note included "administered for verbal agitation." MAR at 5:00 p.m. haloperidol was administered, progress note included "given prior to behaviors." MAR on 7/19/21 at 7:37 a.m. haloperidol was	F 758		

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F 758	Continued From page 19	F 758		

administered. Progress note included, "hollering in the dining room. Everybody is going to die. Pacing in the wheelchair."
MAR on 8/4/21 at 7:15 a.m. haloperidol was administered. Progress note included, "[R1] refusing cares, bath. Very anxious, "I'm gonna melt. I can't get in water" Talked that he was dead."

R1's psychiatric telehealth visit note dated 7/20/21, identified R1's diagnoses and behaviors. The following Plan/orders, 1. Will continue current plan of care. 2) Gradual dose reduction of medications are not clinically indicated due to patients psychiatric symptoms as detailed in progress notes. 3) Continue to encourage non-pharmacological strategies such as music and group activities to help with mood stabilization.

During an observation on 8/4/21, at 6:57 a.m. self-propelling in his wheelchair down the hallway; no behaviors were noted. At 7:05 a.m. R1 stated to nursing assistant (NA)-A he was melting. NA-A told R1 "ok, well I think you have a shower today, do you want a shower?" R1 replied "Not right now!, I'm melting". NA-A asked R1 if he needed to use the bathroom, R1 replied "not right now".

During an interview on 8/4/21, at 7:00 a.m. NA-A stated R1 had behaviors such as refused to be changed when incontinent and physical behaviors toward staff. NA-A stated yesterday he was going to blow everybody up. NA- indicated when R1 had behaviors staff would leave him alone and re-approach him a little later.

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	245536	A. BUILDING _____ B. WING _____	C 08/05/2021

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F 758	Continued From page 20 During a subsequent interview on 8/4/21, at 1:09 p.m. NA-A stated the NA's record behaviors in POC once per shift, and did not document non-pharmacological interventions because there was not a place to document in POC. NA-A stated the number of each behavior was not counted, because that would be too much and there wasn't enough time during the day. NA-A stated they would report if residents had behaviors at the end of the shift to the nurse; nurses were good about asking questions, then the nurse would document in progress notes. During an interview on 8/5/21, at 8:47 a.m. RN-A indicated staff were supposed to document behaviors/interventions in real time to capture the frequency of the behavior to determine trends or if there was improvement or worsening. Interim director of nursing (IDON) confirmed POC did not include an area to document non-pharmacological interventions. IDON indicated the interdisciplinary team reviewed progress notes daily and then evaluated them for behavioral changes; would then update the physician. Vice president of operations (VPO) indicated the facility should be conducting monthly behavior rounds where all the behaviors and interventions are evaluated for effectiveness and/or any improvement/worsening of behaviors. Facility policies PRN psychoactive Medication Guidelines and Adverse Effect Psychoactive Medication monitoring did not include documentation requirements and/or guidelines for the facility's behavioral management program. R18 According to R18's electronic health record	F 758		

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	245536	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	**115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954**

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F 758	Continued From page 21 (EHR) Admission Sheet and a Medical Provider Telehealth Encounter 5/25/21, included diagnosis of Bipolar I disorder (mood disorder than includes depression and also hyperactivity, euphoria and delusions), recurrent major depressive episodes, panic According to R18's EHR a brief progress note dated 5/25/21, 9:58 a.m. indicated a pharmacy medical record review had been done and there was a recommendation to "review PRN Ativan (antianxiety medication, also called Lorazepam) orders for clarification". According to a hard copy document titled Consultant Pharmacist Recommendation to Physician dated 5/25/21, the pharmacist wrote the following in relation to R18's orders: "Recommend discontinuing PRN use of Lorazepam for this resident, or reorder for a specific number of days per the following federal guideline: In accordance with State and Federal Guidelines, revised regulation 483.45(e) psychotropic drugs PRN, orders for psychotropic drugs are limited to 14 days, except when the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Then he or she should document the rational in the Resident's medical record and indicate the duration for the PRN order." The document included a spot to choose either "discontinue this PRN order" or "continue PRN use of Lorazepam for (blank)days, as the benefit outweigh the risk." No response was recorded on the sheet and no corresponding medical provider's signature was observed on the document.	F 758		

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F 758	Continued From page 22 A request was made for evidence of a medical provider response to the 5/25/21 pharmacist recommendations. The facility provided the 5/25/21 telehealth encounter notes. The notes included an extensive list of medications for R18, but failed to include any notation of Ativan/Lorazepam. The note failed to indicate the medical provider had reviewed the pharmacist recommendations, and failed to indicate a stop date or duration for any PRN Ativan/Lorazepam. R17 R17's face sheet dated 8/5/21 indicated a diagnosis of vascular dementia without behavioral disturbance and anxiety. R17's Care Plan last revised on 7/12/21, indicated R17 had severe cognitive impairment. R17's care plan also indicated R17 used antipsychotic medication related to psychosis, anxiety and behaviors of elopement. Interventions included to attempt non-pharmacological interventions and observe effectiveness. Interventions included: talking about favorite topics while providing cares-his years as a bus driver for [name] School, love to tinker with things when he was at home. Direct away from exit and let him know that [name] isn't here at this time to pick him up. Offer coffee/cookie while he waits for [name]. The care plan also indicated the following interventions: Attempt non-pharmacological interventions and observe effectiveness. Interventions include: talking about favorite topics while providing cares-his years as a bus driver for [name] School, love to tinker with things when he was at home. Also Calmly explain that you will	F 758		

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F 758	Continued From page 23 return in a given time and assist with cares. Offer opportunity to walk or wheel to DR [dining room] for coffee and cookie to relax. Physician orders dated 8/5/21 showed R17 was prescribed Lorazepam (used to treat anxiety) 0.5 milligrams every 4 hours as needed (PRN) for restlessness/agitation on 7/6/21. The order lacked a duration for use. R17's record lacked evidence of a physician's evaluation to extend the duration for use of Ativan beyond 14 days. The medication administration record (MAR) showed R17 was given one dose of PRN lorazepam on 7/16/21. Electronic Medication Administration Record (EMAR) note indicated R17 was pulling on other resident's chair constantly with an increased in agitation/anxiety noted. No documentation was found to indicate if any non-pharmacological interventions were utilized prior to the administration of PRN lorazepam. During an interview on 08/05/21, at 01:39 p.m., the director of nursing (DON) verified PRN lorazepam is limited to fourteen days, unless a physician documents a rationale to extend the medication. DON then verified there was no documentation to show R17's order for PRN lorazepam was discontinued or reviewed by a physician after fourteen days. Facility Adverse Effect Psychoactive Medication Monitoring Policy, last revised 9/2020, did not include parameters for monitoring PRN lorazepam every fourteen days.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		9/8/21

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F 880	Continued From page 24 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 25 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to have appropriate placement of personal protective equipment (PPE) for a dedicated isolation unit where a COVID-19 positive resident resided. In addition the facility failed to ensure visitors and/or essential care givers followed appropriate doffing procedures and hand hygiene. The facility's	F 880	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond	

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F 880	Continued From page 26 failures had the potential to affect all residents, staff and visitors. Findings include Upon entrance to the facility on 8/2/21, at 1:30 p.m. administrator stated the facility had one resident (R23) who tested positive for Covid-19; R23 resided down the 300 hallway which was designated as the facility's isolation unit. The interim director of nursing (IDON) stated R23 had been admitted to the facility on 6/28/21, from the hospital positive with Covid. IDON indicated R23 then was readmitted to the hospital a couple of weeks ago; during the hospitalization R23 tested positive again prior to being readmitted back to the facility on 7/30/21. R23's hospital discharge summary dated 7/30/21, indicated R23 was admitted to the hospital on 7/23/21 and discharged to the facility on 7/30/21. The summary included "patient has a positive nasal PCR on admission [to the hospital on 7/23/21], which initially was felt to likely represent recent infection. Unfortunately, confirmatory antibody testing returned negative- so patient was started on Remdesivir (antiviral medication), dexamethasone (steroid medication), and provided convalescent plasma." The summary included lab results which identified R23 tested positive for SARS-Coronavirus-2 on 7/29/21 via nasopharyngeal swab. During an interview on 8/2/21, at 1:57 p.m. licensed practical nurse (LPN)-A indicated R23 resided in the isolation unit and did not have any respiratory symptoms, however, R23 had diminished lung sounds.	F 880	chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 880 Infection Control Green Lea Senior Living corrected the deficiency by 8-5-21. Family members for R23 were educated as of 8-4-21 or prior to their next visit by the DON or Administrator on PPE requirements and hand hygiene requirements. A new location for PPE was placed outside of the Covid Unit for availability prior to entering the unit. All staff entering a COVID unit were educated on the proper disposal of PPE. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated 09-02-2021 and 09-03-2021 on the policy for Compassionate Care Indoor visitation process and the placement and proper utilization of PPE by Administrator or DON. Staff were educated to encourage the visitors to pull the call cord before leaving so staff could assist with removing PPE properly and ensuring new PPE was used as appropriate. Staff were also instructed to have visitors enter and leave from the South entrance/exit door. The DON and/or designee will randomly audit staff and visitors for appropriate donning/doffing and hand hygiene weekly x4 weeks, then monthly x3months to ensure continued compliance. 3. As part of Green Lea Senior Living	

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F 880	Continued From page 27 The isolation unit was observed on 8/2/21, at 2:16 p.m., there was a sign on the doorway to the unit that directed to put on personal protection equipment (PPE) (face mask, face shield, and gown) prior to entering the unit, however there was not PPE located outside the unit, nor was there a hand hygiene station and/or hand sanitizer in the near vicinity of the isolation unit. Inside the isolation unit, outside R23's door there was soiled linen/PPE containers and across the hallway from R23's room, was a room that had uncovered clean PPE, medical equipment, and cleaning supplies. A gown hung on the doorway of this room. During an interview on 8/2/21, at 2:21 p.m. nursing assistant (NA)-C indicated she had not cared for R23 since she was re-admitted to the facility. NA-C stated she would enter the isolation unit, then go the room across from R23's room to put on the PPE. NA-C stated she would then take off the PPE in the same room. NA-C stated she would perform hand hygiene in that room and then exit the isolation unit. During an observation on 8/2/21, at 5:00 p.m. an unidentified visitor (UV)-1 came out of the room across from R23's without PPE on (gown, gloves, mask, eye/face shield), carrying a crumpled-up gown against body, through the gown in the receptacle by R23's door, and placed the face shield on top of the receptacle. UV-1 then opened the door to exit the isolation unit, did not perform hand hygiene before using the near by door to exit the building. At approximately 5:02 p.m. a second unidentified visitor (UV)-2 walked out of the room across R23's without PPE on,	F 880	ongoing commitment to quality assurance, DON and/or designee will report identified concerns through the community□s QA Process.	

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F 880	Continued From page 28	F 880		

UV-2 carried gown across the hallway, opened the soiled receptacle, donned a cloth face mask, and opened the door leading out of the isolation unit. UV-2 stated that hand hygiene was performed in the room across from R23's room; there was a sink in the bathroom. UV-2 then exited the facility.

During an interview on 8/3/21, at 2:34 p.m. medical doctor (MD)-A indicated R23 was his patient. MD-A indicated since R23 tested positive in the hospital and tested negative for antibodies, the protocols would be followed for "new case" of Covid. MD-A indicated an unawareness of the facility's specific COVID-19 protocols were for isolation and placement of PPE for entering the isolation unit.

During an observation on 8/3/21, at 3:30 p.m. PPE and hand sanitizer was on a table outside of the isolation unit.

During an observation and interview on 8/4/21, at 7:15 a.m. there was a face shield and gown hanging on the wall outside of R23's. There was also a gown hanging on the door across from R23's room. R23 sat in recliner with oxygen on via nasal cannula. R23 stated she had an occasional cough, however, did not cough while surveyor was in the room. Interim director of nursing (IDON) indicated staff should not be reusing PPE. IDON indicated prior to R23's admission to the facility, PPE used to be located outside the isolation unit, however when the unit was not being utilized the equipment was moved inside the unit for storage. IDON stated PPE should be donned prior to entering the unit and doffed prior to exiting the unit. Hand hygiene

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F 880	Continued From page 29 should be used after exiting the unit. During an observation on 8/4/21, at 11:15 a.m. LPN-A assisted unidentified visitor (UV)-3 with donning PPE, LPN-A quickly informed UV-3 to take off the equipment prior to exiting the unit and that there was signs on how to remove the PPE outside R23's door. At 11:40 a.m. UV-3 exited the unit without a face mask holding face shield and grabbed a new mask from a box located on the PPE table. UV-3 asked surveyor (no staff were in the area) "What should I do with this [face shield]?" UV-3 placed the shield on the table, surveyor instructed UV-3 to use hand sanitizer, UV-3 then exited the facility. During an interview on 8/4/21, at 1:54 p.m. infection control director (ICD) indicated visitors had to be screened in, visitors were required to wear the appropriate PPE for the isolation unit. ICD indicated the facility should have a process in place that ensured visitors and essential care givers followed infection control procedures for Covid-19 positive residents to protect themselves, other residents, outside community, and staff. ICD indicated staff would be re-educated on providing visitors/essential care givers with education on following PPE guidelines for donning/doffing and ensuring visitors followed the procedures. Accura Essential Caregivers Process dated 5/10/21 included, Essential Caregivers (EC) must go through our essential caregiver orientation training and have documented, which includes review of proper infection control, screening, use of personal protective equipment, visitation terms, and triggers for pausing EC visits. The	F 880		

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F 880	Continued From page 30 worksheet once completed, outlined where ECs should enter, check in, location of hand hygiene performed, where to check out, and exit. EC's must wear facemask the entire time they are in the facility. Policy COVID-19 Indoor Visitation Process dated 5/10/21, Core Principles of Visitors: Hand Hygiene prior to visiting and/or after using restroom or touching surfaces, proper visitor education on infection control precautions, other applicable facility practices, appropriate visitor use of PPE, Policy included same direction as the essential care giver process. Policy for PPE donning/doffing and/or isolation unit was not provided and or included in the policies that were provided.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		9/8/21

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F 947	Continued From page 31 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Alzheimer's/dementia training was provided to staff during orientation and prior to working with residents for 5 of 5 newly hired staff (E-1, E-2, E-3, E-4, and E-5). This had the potential to affect all residents in the facility. Findings include On 8/5/21, administrator provided the last 5 staff who hired with their hire dates: Employee 1 (E-1) was hired on 7/6/21 E-2's hire date was 7/8/21 E-3's hire date was 7/12/21 E-4's hire date was 7/20/21 E-5's hire date was 7/28/21 During an interview on 8/5/21 at 1:45 p.m. the administrator stated the five new employees hired NH-1, NH-2, NH-3, NH-4, and NH-5 were not provided with dementia care training as part of their orientation process. Administrator indicated staff complete learning modules on a software driven education center. Administrator indicated the dementia modules were not assigned as part of the orientation process and should have been. Policy was not provided	F 947	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 947 Required In-service training for Nurse Aides Green Lea Senior Living corrected the deficiency by auditing new staff for the need to complete the Alzheimer□s/Dementia Training. Employee # 1,2,3,4 completed dementia training on 8-31-21, 8-26-21, 8-31-21, and 8-29-21. Employee #5 completed dementia training on 9-2-21. On 9-2-2021 we audited all staff for dementia training. 2. To correct the deficiency and to ensure the problem does not recur our staff orientation designee was educated 09/01/2021 the requirement to complete Dementia Training during orientation. The Administrator and/or designee will audit all new hires to ensure Dementia training is completed during orientation weekly x4	

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F 947	Continued From page 32	F 947	weeks, then monthly x3 months to ensure continued compliance. 3. As part of Green Lea Senior Living ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community□s QA Process.	

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	245536	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA SENIOR LIVING	**115 NORTH LYNDALE, 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 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 08/03/2021. 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		09/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 by a 2 hour fire separation.	K 000		

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K 000	Continued From page 2 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, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 41 beds and had a census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper exit discharge to a public way in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.6.3, 7.1.10. This deficient condition	K 271	K271: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the	9/30/21

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K 271	Continued From page 3 could have an isolated impact on the residents within the facility. Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed that the South exit sidewalk had multiple concrete sections that were in a state-of-disrepair consisting of crumbling concrete. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 271	facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 9-03-2021 a Contractor from 3D construction came onsite to review the South exit sidewalk. He has agreed to the job. The job to fix the South exit sidewalk will be completed by 9-30-2021. 2. The Maintenance Director audit exit doors 1x month for 3 months to ensure they are safe and free from obstruction. This has been added to our TELS preventative maintenance program. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 4. The Maintenance Supervisor is responsible for this area of compliance.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 291		9/8/21

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K 291	Continued From page 4 Based on observation and staff interview, the facility failed to confirm operability of emergency lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed that the emergency light located in the facility Boiler Room, Laundry Area, and Generator Room did not function upon testing. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 291	K291: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 08-31-2021 all three batteries that operate emergency lighting in the facility Boiler Room, Laundry Area, and Generator Room were replaced by the Maintenance director. 2. Will audit emergency lighting 1x month for 3 months to ensure emergency lighting is working properly. This has been added to our TELS preventative maintenance program. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 4. 4. The Maintenance Supervisor is responsible for this area of compliance.	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		9/8/21

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K 345	Continued From page 5 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect, maintain, and follow policy associated to the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.2.7, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.1.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed that the manual pull-station in the Activities Room was obstructed This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	K345: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 8/3/2021the maintenance director cleared the plant that was obstructing manual pull-station in the activity room. 2. Will audit manual pull stations 1x month for 3 months to ensure emergency lighting is working properly. This has been added to our TELS preventative maintenance program. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and	

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K 345	Continued From page 6	K 345	continued monitoring. 4. The Maintenance Supervisor is responsible for this area of compliance.	
K 353 SS=F	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, 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 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2. NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. This deficient condition could have a	K 353	K353: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement,	9/8/21

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K 353	Continued From page 7 widespread impact on the residents within the facility. Findings include: 1. On 08/03/2021 between 10:00 AM to 03:00 PM,, it was revealed the ceiling outside of the Activities Room was missing ceiling tile 2. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed the sprinkler heads in the Laundry Room exhibited signs of corrosion and oxidation 3. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed during a random inspection of resident room closets in Wings 100, 200, 400, that sprinkler heads were obstructed by high storage of supplies (RM 110 / RM 403 / RM 204) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	the facility states that with respect to: 1. On 8/3/2021 the maintenance director replaced the ceiling tile outside of the Activities Room. 2. On 8/16/2021the sprinkler heads in the Laundry Room were replaced by the Maintenance director. 3. On 8/31/2021 the following rooms were audited and are no longer obstructed by high storage of supplies, RM 110 /RM 403 / RM 204. Staff were educated on 09/02/2021 and 09/03/2021 to ensure closets are free of high storage supplies. 4. Will audit ceiling tiles that are in need of repair, sprinkler heads that need to be replaced due to corrosion, and ensuring no obstruction 1x month for 3 months. 5. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 6. The Maintenance Supervisor is responsible for this area of compliance.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		9/8/21

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K 355	Continued From page 8 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.8. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed that fire extinguisher located in the Activities Room was access obstructed This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 355	K355: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 8/3/2021 the plant that was obstructing the fire extinguisher was removed by the Maintenance Director. 2. Will audit fire extinguisher accessibility 1x month for 3 months. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 4. The Maintenance Supervisor is responsible for this area of compliance.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511		9/8/21

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K 511	Continued From page 9 complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security and physical accessibility to electrical panel in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed that there was obstructed access to the electrical panel in the Activity Room / Sprinkler Riser Closet 2. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed upon testing that electrical panel #13 was unsecured in a resident accessible corridor This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 511	K511: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 8/4/2021 the activity supplies obstructing the electrical panel in the Activity Room/Sprinkler Riser Closet was cleared by the Maintenance Director. On 8/3/2021 panel #13 was secured. 2. Will audit all electrical panel accessibility 1x a month for 3 months. Will audit panel #13 1x for 3 months to ensure it□s secure. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement	

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K 511	Continued From page 10	K 511	Committee quarterly for further recommendations regarding system and continued monitoring. 4. The Maintenance Supervisor is responsible for this area of compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review that no records were available for review to confirm that fire drills were conducted: 2nd shift - Quarter 1 and 3rd shift - Quarter 2	K 712	K712: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 08/16/2021 the Maintenance Supervisor audited all quarterly fire drills	9/8/21

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K 712	Continued From page 11 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 712	and a tracking system was implemented to ensure all shifts are completed with staggered times. TELS preventative maintenance program up to date on monthly fire drills every shift every quarter is completed. 2 Administrator will audit tracking system 1x month for 3 months fire drills are being completed for different shifts. 3 The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further 4 The Maintenance Supervisor is responsible for this area of compliance.	
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. 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:	K 761		9/8/21

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(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 761	Continued From page 12 Based on document review and staff interview, the facility failed to maintain, inspect and test the exit door in the facility per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15 and NFPA 80 (2010 edition), Standards for Fire Doors and Other Opening Protectives, sections 5.2.1 This deficient condition could have an widespread impact on the residents within the facility. Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review, that no records were presented for review to confirm that inspection and testing of fire door assemblies had been completed This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 761	K761: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 8/19/2021 a tracking system was implemented to ensure fire door testing and inspection is audited on a routine basis. 2. Administrator will audit tracking system 1x month for 3 months. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 4. The Maintenance Supervisor is responsible for this area of compliance.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920		9/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2021**

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K 920	Continued From page 13 (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have a patterned impact on the residents within the facility. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed in Scheduler Office that a power strip was in use to power appliances (air conditioner unit and refrigerator)	K 920	K920: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 8/3/2021 power strip was removed from Scheduler Office. 2. On 8/3/2021 power strips were corrected/removed of daisy-chain at	

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K 920	Continued From page 14 2. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed in core Nurses Station that power strips were daisy-chained together and supplying power to devices 3. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed in RM 113 that an extension cord was in use to power a device 4. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed in the Admin Office that power strips were daisy-chained together and supplying power to devices 5. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed in the Business Office that power strips was in use to power appliances (dehumidifier) 6. On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed in the Business Office that an extension cord was in use to power a device This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 920	Nurses Station. 3. On 8/3/2021 extension cord removed from RM 113. 4. On 8/3/2021 power strips were corrected/removed of daisy-chain in the Amin Office. 5. On 8/3/2021 power strip was removed from Business Office. 6. On 8/3/2021 extension cord was removed from Business Office. 7. Maintenance Director and/or his designee will audit all offices 1x month for 3 months to ensure correct usage of power strops. 8. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 9. The Maintenance Supervisor is responsible for this area of compliance.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		9/8/21

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K 923	Continued From page 15 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.4, 11.6.5 This deficient condition could have an widespread impact on the residents within the facility.	K 923	K923: The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of	

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K 923	Continued From page 16 Findings include: On 08/03/2021 between 10:00 AM to 03:00 PM, it was revealed that the Med Gas Storage Room had proper in-room signage but mixed storage of empty / full cylinders This deficient practice was confirmed by the Maintenance Director at the time of discovery	K 923	correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 08/03/2021 mixed storage of empty/full cylinders were audited by the Maintenance Director and cylinders were put in the correct areas in Med Gas Storage Room. All staff were educated on 9/3/21 by the DNS on the proper storage of oxygen cylinders. 2. Maintenance Director and/or his designee will audit the oxygen room to ensure empty and full cylinders aren□t mixed 1x month for 3 months. 3. The Maintenance Director and/or his designee will present the data to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring. 4. The Maintenance Supervisor is responsible for this area of compliance.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 27, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: GROF11

Dear Administrator:

The above facility was surveyed on August 2, 2021 through August 5, 2021 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, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00124	A. BUILDING: _____ B. WING _____	C 08/05/2021

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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 8/2/21 through 8/5/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 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	2 000		

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2 000	Continued From page 2 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		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		9/8/21

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2 302	Continued From page 3 by: Based on interview and document review, the facility failed to ensure Alzheimer's/dementia training was provided to staff during orientation and prior to working with residents for 5 of 5 newly hired staff (E-1, E-2, E-3, E-4, and E-5). This had the potential to affect all residents in the facility. Findings include On 8/5/21, administrator provided the last 5 staff who hired with thier hire dates: Employee 1 (E-1) was hired on 7/6/21 E-2's hire date was 7/8/21 E-3's hire date was 7/12/21 E-4's hire date was 7/20/21 E-5's hire date was 7/28/21 During an interview on 8/5/21 at 1:45 p.m. the administrator stated the five new employees hired NH-1, NH-2, NH-3, NH-4, and NH-5 were not provided with dementia care training as part of their orientation process. Administrator indicated staff complete learning modules on a software driven education center. Administrator indicated the dementia modules were not assigned as part of the orientation process and should have been. Policy was not provided SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who	2 302	Corrected.	

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2 302	Continued From page 4 request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively	2 830	Corrected.	9/8/21

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2 830	Continued From page 5 assess each fall, identify causative factors to determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 1 of 2 residents (R17) reviewed for accidents. Findings include: Minimum Data Set (MDS) completed on 6/11/21, indicated R17 was a one person physical assist with bed mobility, personal hygiene and bathing and a two person physical assist with transfers and toileting. Primary medical condition listed on MDS was debility and cardiorespiratory conditions. R17's face sheet diagnoses of unspecified psychosis, vascular dementia, anxiety disorder and anoxic (when the body does not get any oxygen) brain damage. R17's Fall Risk Assessment dated 4/3/2021 indicated R17 was at a high fall risk with a score of 80 on the Morse Fall Scale, a method of assessing a resident's likelihood of falling. R17's medical record indicated R17 had sustained 10 falls between 3/9/21 and 8/5/21. R17's care plan included, "Resident has had multiple falls with hx[sic] of major injury (hip fracture)and also minor injuries such as skin tears d/t poor balance, poor comprehension, unaware of safety risks and unsteady gait R/T over all functional and cognitive decline." Interventions included, "Anticipate needs, particularly when he appears anxious or restless but also with each interaction. Coordinate with appropriate staff to ensure a safe environment	2 830		

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2 830	Continued From page 6 with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed at appropriate height, Grab bar/U-bar as ordered, Handrails on walls, Personal items within reach. Frequent checks by staff. Offer toileting each time. Provide reminders to wait for assist from staff." Incident report dated 3/9/21 indicated R17 had eloped from the building at 9:45 P.M., where he sustained a fall resulting in a skin tear to left elbow, scrape to left pinky finger and a purple bruise on left elbow. No immediate intervention was noted on the incident report and a post fall evaluation was not supplied by the facility when requested. Incident report dated 3/24/21 indicated R17 sustained a fall in his room while standing up attempting to put his belt on. No immediate intervention was noted on the incident report. Post fall data collection form indicated intervention implemented was to educate resident to ask for assistance. Potential root cause was medical status/physical condition/diagnosis and no changes made to care plan. Incident reported dated 4/12/21 indicated R17 sustained a fall at 3:30 P.M. in the main lobby when standing with his walker. No immediate intervention was noted on the incident report and a post fall data collection was not supplied by the facility when requested. Incident report dated 4/27/21 indicated R17 was found sitting on the floor in his room at 12:30 A.M. and was unable to say what happened. R17 sustained a skin tear on left elbow. Immediate	2 830		

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2 830	Continued From page 7 intervention was R17 was taken to the dining room and given a cup of coffee. No post fall evaluation was supplied by facility when requested. Incident report dated 5/21/21 indicated R17 was observed in his room kneeling in front of his wheelchair trying to get up at 3:30 P.M. R17 stated he fell from his wheelchair when attempting to pick something up from the floor. R17 sustained a C-shaped laceration on the right side of his head that measured 1.5 inches and a skin tear on left wrist measuring 0.5 inches. No immediate interventions were noted in the incident report and no post fall evaluation was supplied by facility when requested. Incident report dated 5/26/21 indicated R17 was found kneeling on the floor of his room in front of his wheelchair at 3:23 P.M. R17 was incontinent of bowel and sustained a skin tear to his left wrist. Immediate intervention was frequent checks. No post fall evaluation was supplied by facility when requested. Incident report dated 6/15/21 indicated a staff member was walking by R17's room at 8:15 A.M. and observed him standing in the middle of the room when he lost his balance and fell to the floor. R17 sustained a skin tear to his left elbow and had a small bruise there as well. No immediate intervention was identified on the incident form. Post fall evaluation indicated interventions utilized were to rearrange R17's room, declutter room and keep mobility device at bedside. No changed were made to the care plan. Incident report dated 6/19/21 indicated R17 was	2 830		

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2 830	Continued From page 8 found on the floor in his room at 1:59 P.M. R17 was toileted just prior to the fall and R17 stated he was "trying to get out of here." R17 sustained a skin tear to his left inner elbow measuring 0.5 centimeters. No immediate intervention noted on incident report. Post fall intervention indicated interventions included keeping mobility device at bedside. No changes were made to the care plan. Incident report dated 7/14/21 indicated R17 was found sitting on the bathroom floor with gripper socks on holding onto a urinal and there was urine on the floor. R17 was placed in bed thirty minutes prior per report. Immediate intervention was to bring R17 out to the lobby. Post fall evaluation indicated no interventions were put into place and no changed were made to the care plan. Incident report dated 7/15/21 indicated R17 was found on the floor of his room with his back resting against television stand. A glass of water was noted to have been spilled on the floor. Immediate intervention was frequent checks. Post fall evaluation indicated interventions included frequent visual checks and no changes were made to the care plan. A post fall evaluation dated 7/16/21 indicated R17 was found on the floor of his room at 7:00 P.M. and sustained a bruise and abrasion to the front of right knee. Interventions included self locking brakes to wheelchair and review/adjust toileting schedule. The evaluation did not indicate if the care plan was updated. During an interview on 8/5/21, at 1:18 p.m., Director of Nursing (DON) was unable to identify	2 830		

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2 830	Continued From page 9 an investigation was completed in order to identify the root cause of 7 of 9 falls that occurred on the following dates: 3/9/21, 4/27/21, 5/21/21, 5/26/21, 6/15/21, 6/19/21, 7/14/21. DON was asked if more should have been done to help prevent further falls from occurring and DON stated, "I cannot answer your question because I do not know what they did." Facility's fall policy was requested on 8/5/21 and not provided. A policy titled Adverse Event Reports-Electronic Record Completion was supplied which outlined instructions on completing incident reports within the electronic medical record, including but not limited to completing an adverse event form in the electronic medical record that includes details of the incident, injuries, predisposing factors, witnesses if applicable and action taken. The interdisciplinary team (IDT) then completes the note section to include root cause analysis of incident and interventions initiated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for resident' falls; then revise as needed to ensure the comprehensive assessment and care planning of such events; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 860		9/8/21

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2 860	Continued From page 10 adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide and/or arrange proper foot care for 1 of 3 (R11) who requested to see a podiatrist for long toenails. Findings include: During an observation and interview on 8/2/21, at 4:05 p.m. R11 was walking in his room barefoot. R11 had very long toenails; nails were grown past the end of the toes. The toenails of the 3rd toe on both feet were up against the second toes. R11 stated he could not trim his own toenails and he needed to go to the podiatrist. R11 stated the nail on the one toe digs into the toe next to it, sometimes it would hurt but not right now. R11 indicated staff did not trim his toenails because they were done by the podiatrist. R11's admission Minimum Data Set (MDS) dated 5/20/21, indicated R11 had moderate cognitive impairment and did not have rejection of care behaviors. The MDS identified R11 required extensive assist from one staff for dressing and limited assistance for personal hygiene. The MDS indicated R11 was at risk for pressure ulcers and did not have any skin concerns at the time of assessment. R11's Body Audit dated 6/16/21, included "Toenails are not clean or trimmed at this time."	2 860	Corrected.	

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2 860	Continued From page 11 R11's Body Audit dated 6/23/21, included, "Toenails and trimmed at this time. Inspection of feet ankles and toes indicate callous overlapping toes" and indicated "family contacted regarding need to see podiatrist" R11's Body Audit dated 6/30/21, included "Toenails are not clean or trimmed at this time" and Callous overlapping toenail deformities. R11's Body Audit dated 7/7/21, included, "Toenails are not clean or trimmed at this time" and Callous overlapping toenail deformities. R11's Body Audit dated 7/14/21, included, "Toenails are not clean or trimmed at this time. Inspection of feet, ankles and toes indicated they are clearoverlapping [sic] toes" R11's Body Audit dated 7/21/21, included, "Toenails are not clean or trimmed at this time" and inspection identified overlapping toenail deformities." During an observation on 8/4/21, at 10:10 a.m. R11 stood in his room with bare feet. R11's toenails were the same length as observed on 8/2/21. During an interview on 8/4/21, at 7:03 a.m. nursing assistant (NA)-A indicated podiatry did not come to the facility; residents had to go to an outside podiatry clinic. During an interview on 8/4/21, at 8:02 a.m. NA-B stated there was not a podiatrist that had come to the facility at all, stated last week a few residents were taken to the podiatrist. NA-B stated she	2 860		

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2 860	Continued From page 12 gave R11 a bath last week and did not cut his toenails because they were "super thick, so I reported to the nurse." During an interview on 8/4/21, at 10:15 a.m. licensed practical nurse (LPN)-A observed R11's feet, "indicated his toenails were long" LPN-A stated there has been a callous on his one second toe because of the long toenail, however, was not there now. LPN-A indicated she has offered to trim R11's toenails, "he told me he wanted to go to the podiatrist." LPN-A stated nursing could probably cut some of the nails that were not so thick; a physician could cut them. LPN-A indicated it was the facility's responsibility to make appointments and set up the transportation, however the facility was waiting for R11's family to get back to them when it was a good time for them. During an interview on 8/5/21, licensed social worker (LSW) stated she helped make transportation arrangements to dental and vision appointments and could assist with podiatry however had not been asked to. LSW stated R11's family take care of his appointments based on their schedule. LSW indicated, the follow-up should have been completed to ensure R11 had necessary foot care done in a timely manner. Facility did not provide a policy SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assess residents foot care needs and/or resident preferences for foot care and revise care plan	2 860		

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2 860	Continued From page 13 based on the assessment and/or resident choice. The DON/designee could then designate staff members to ensure podiatry appointment and transportation arrangements are made in a timely manner after assessment identified the concern. The DON/designee could communicate to family members the importance of providing foot care in a timely manner. The DON/designee could then develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of	21390		9/8/21

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21390	Continued From page 14 products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to have appropriate placement of personal protective equipment (PPE) for a dedicated isolation unit where a COVID-19 positive resident resided. In addition the facility failed to ensure visitors and/or essential care givers followed appropriate doffing procedures and hand hygiene. The facility's failures had the potential to affect all residents, staff and visitors. Findings include Upon entrance to the facility on 8/2/21, at 1:30 p.m. administrator stated the facility had one resident (R23) who tested positive for Covid-19; R23 resided down the 300 hallway which was designated as the facility's isolation unit. The interim director of nursing (IDON) stated R23 had been admitted to the facility on 6/28/21, from the hospital positive with Covid. IDON indicated R23 then was readmitted to the hospital a couple of weeks ago; during the hospitalization R23 tested positive again prior to being readmitted back to the facility on 7/30/21. R23's hospital discharge summary dated 7/30/21, indicated R23 was admitted to the hospital on 7/23/21 and discharged to the facility on 7/30/21. The summary included "patient has a positive	21390	Corrected.	

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21390	Continued From page 15	21390		

nasal PCR on admission [to the hospital on 7/23/21], which initially was felt to likely represent recent infection. Unfortunately, confirmatory antibody testing returned negative- so patient was started on Remdesivir (antiviral medication), dexamethasone (steroid medication), and provided convalescent plasma." The summary included lab results which identified R23 tested positive for SARS-Coronavirus-2 on 7/29/21 via nasopharyngeal swab.

During an interview on 8/2/21, at 1:57 p.m. licensed practical nurse (LPN)-A indicated R23 resided in the isolation unit and did not have any respiratory symptoms, however, R23 had diminished lung sounds.

The isolation unit was observed on 8/2/21, at 2:16 p.m., there was a sign on the doorway to the unit that directed to put on personal protection equipment (PPE) (face mask, face shield, and gown) prior to entering the unit, however there was not PPE located outside the unit, nor was there a hand hygiene station and/or hand sanitizer in the near vicinity of the isolation unit. Inside the isolation unit, outside R23's door there was soiled linen/PPE containers and across the hallway from R23's room, was a room that had uncovered clean PPE, medical equipment, and cleaning supplies. A gown hung on the doorway of this room.

During an interview on 8/2/21, at 2:21 p.m. nursing assistant (NA)-C indicated she had not cared for R23 since she was re-admitted to the facility. NA-C stated she would enter the isolation unit, then go the room across from R23's room to put on the PPE. NA-C stated she would then take off the PPE in the same room. NA-C stated she

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21390	Continued From page 16 would perform hand hygiene in that room and then exit the isolation unit. During an observation on 8/2/21, at 5:00 p.m. an unidentified visitor (UV)-1 came out of the room across from R23's without PPE on (gown, gloves, mask, eye/face shield), carrying a crumpled-up gown against body, through the gown in the receptacle by R23's door, and placed the face shield on top of the receptacle. UV-1 then opened the door to exit the isolation unit, did not perform hand hygiene before using the near by door to exit the building. At approximately 5:02 p.m. a second unidentified visitor (UV)-2 walked out of the room across R23's without PPE on, UV-2 carried gown across the hallway, opened the soiled receptacle, donned a cloth face mask, and opened the door leading out of the isolation unit. UV-2 stated that hand hygiene was performed in the room across from R23's room; there was a sink in the bathroom. UV-2 then exited the facility. During an interview on 8/3/21, at 2:34 p.m. medical doctor (MD)-A indicated R23 was his patient. MD-A indicated since R23 tested positive in the hospital and tested negative for antibodies, the protocols would be followed for "new case" of Covid. MD-A indicated an unawareness of the facility's specific COVID-19 protocols were for isolation and placement of PPE for entering the isolation unit. During an observation on 8/3/21, at 3:30 p.m. PPE and hand sanitizer was on a table outside of the isolation unit. During an observation and interview on 8/4/21, at 7:15 a.m. there was a face shield and gown	21390		

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21390	Continued From page 17 hanging on the wall outside of R23's. There was also a gown hanging on the door across from R23's room. R23 sat in recliner with oxygen on via nasal cannula. R23 stated she had an occasional cough, however, did not cough while surveyor was in the room. Interim director of nursing (IDON) indicated staff should not be reusing PPE. IDON indicated prior to R23's admission to the facility, PPE used to be located outside the isolation unit, however when the unit was not being utilized the equipment was moved inside the unit for storage. IDON stated PPE should be donned prior to entering the unit and doffed prior to exiting the unit. Hand hygiene should be used after exiting the unit. During an observation on 8/4/21, at 11:15 a.m. LPN-A assisted unidentified visitor (UV)-3 with donning PPE, LPN-A quickly informed UV-3 to take off the equipment prior to exiting the unit and that there was signs on how to remove the PPE outside R23's door. At 11:40 a.m. UV-3 exited the unit without a face mask holding face shield and grabbed a new mask from a box located on the PPE table. UV-3 asked surveyor (no staff were in the area) "What should I do with this [face shield]?" UV-3 placed the shield on the table, surveyor instructed UV-3 to use hand sanitizer, UV-3 then exited the facility. During an interview on 8/4/21, at 1:54 p.m. infection control director (ICD) indicated visitors had to be screened in, visitors were required to wear the appropriate PPE for the isolation unit. ICD indicated the facility should have a process in place that ensured visitors and essential care givers followed infection control procedures for Covid-19 positive residents to protect themselves, other residents, outside community,	21390		

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21390	Continued From page 18	21390		

and staff. ICD indicated staff would be re-educated on providing visitors/essential care givers with education on following PPE guidelines for donning/doffing and ensuring visitors followed the procedures.

Accura Essential Caregivers Process dated 5/10/21 included, Essential Caregivers (EC) must go through our essential caregiver orientation training and have documented, which includes review of proper infection control, screening, use of personal protective equipment, visitation terms, and triggers for pausing EC visits. The worksheet once completed, outlined where ECs should enter, check in, location of hand hygiene performed, where to check out, and exit. EC's must wear facemask the entire time they are in the facility.

Policy COVID-19 Indoor Visitation Process dated 5/10/21, Core Principles of Visitors: Hand Hygiene prior to visiting and/or after using restroom or touching surfaces, proper visitor education on infection control precautions, other applicable facility practices, appropriate visitor use of PPE, Policy included same direction as the essential care giver process.

Policy for PPE donning/doffing and/or isolation unit was not provided and or included in the policies that were provided.

SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily procedures for donning/doffing PPE in COVID-19 unit and ensure the appropriate use of PPE by visitor

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 19 and/or essential caregivers who visit COVID-19 positive residents. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		9/8/21

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21426	Continued From page 20 This MN Requirement is not met as evidenced by: Based on record review and interview the facility failed to ensure TB (tuberculosis) symptom screeners were completed for 1 of 5 residents (R99) and failed to ensure first and/or second step Tuberculin Skin Test (TST) were administered to 4 of 5 residents (R99, R11, R14, and R15), and failed to ensure a second step TST included date and time of when the TST was read. In addition, the facility failed to ensure TB symptom screeners were completed upon hire for 3 of 5 employees (E-3, E4, and E-5) and failed to ensure 4 of 5 employees (E-1, E-3, E-4, and E-5) were administered first and/or second step TST's. Findings include RESIDENTS R99 admitted to the facility on 6/22/21, R99's record did not include a TB symptom screener. R99's record identified first step TST was administered on 6/22/21, at 8:30 p.m. however lacked evidence the TST was read for results. R11 admitted to the facility on 5/14/21. R11's record lacked evidence TST's were administered after admission to the facility. R14 admitted to the facility on 3/25/21. R14's record lacked evidence a second step TST was administered after the first step was read for zero/negative on 3/28/21. R15 admitted to the facility on 3/4/21, R15's record lacked evidence TST's were administered. R228 admitted to the facility on 7/20/21. R228's	21426	Corrected.	

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21426	Continued From page 21 record identified R228 was administered the second step TST on 7/30/21. Although R228's record identified the results were negative; the record lacked identification of the date and time the test was read for results. EMPLOYEES Employee-1 (E-1) had a hire date of 7/8/21. E-1's record lacked evidence a second step TST was administered. E-3's record identified a hire date on 7/12/21, E-3's record did not include a TB symptom screen and lacked evidence TST's were administered. E-4's record identified a hire date of 7/20/21, E-4's record did not include a TB symptom screen and lacked evidence TST's were administered. E-5's record identified a hire date of 7/28/21, E-5's record did not include a TB symptom screen and lacked evidence TST's were administered. During an interview on 8/5/21, at 12:47 p.m. interim director of nursing (IDON), reviewed resident and employee TB records. IDON confirmed R99's record did not include a TB symptom screener nor evidence TST's were completed. IDON stated R14 received the 1st step TST and did not receive the second step, for R228 could not find where staff had documented the date and time of the results. IDON stated R11 and R15 were not administered any TST's since admission. During an interview on 8/5/21, at 1:00 p.m.	21426		

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21426	Continued From page 22 administrator stated E-3, E-4, and E-5's records did not include a TB symptoms screener and were not administered TST. Administrator indicated E-1 was not administered the second step TST. Facility policy TB Infection Control Plan dated 5/21/21, included a section Screening Health Care workers, the section included: Baseline screening is required for all health care workers. Baseline screening consists of three components: assessing for current symptoms of active TB disease, Assessment of TB history and Testing for the presence of m-tuberculosis by administering the two-step TST or single IGRA. An employee may only begin direct care after a negative TB symptoms screen and a negative IGRA or 1st step TST. The policy also included the three components for screening residents and directed staff to complete the assessment for risk factors, TB history, and current symptoms of TB is completed upon admission. The policy did not include instructions for recording the date and time that the TST's were read. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing for tuberculosis for residents and employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions, current residents records, and staff to ensure compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI)	21426		

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21426	Continued From page 23 committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21535	Corrected.	9/8/21

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21535	Continued From page 24 review the facility failed to offer/attempt non-pharmacological interventions prior to administration of as needed (PRN) antipsychotic medication for 1 of 5 (R1) reviewed for unnecessary medications. In addition, the facility failed to ensure as needed (PRN) antipsychotic medications were limited to 14 days unless there was documented physician assessment of justification for continued use for 2 of 5 residents (R17 & R18) reviewed for unnecessary medications. Findings include: R1's face sheet dated 8/5/21, included diagnoses of dementia with behavioral disturbance and major depressive disorder. R1's annual Minimum Data Set (MDS) assessment dated 8/4/2021, identified R1 had severe cognitive impairment, had symptoms of delirium. MDS indicated R1 did not have hallucinations/delusion, demonstrated behavior not directed towards other 1 to 3 days, and wandering behaviors one to three days. The MDS indicated those behaviors worsened since the previous assessment. MDS indicated R1 was administered an antidepressant medication and was not administered an antipsychotic. R1's behavioral care plan included the following: -[R1] has exhibit the following behaviors: isolated incidents of verbal and physical abuse toward staff. Three incidents in dining room. Uncertain of trigger in dining room. At this time [R1] has not require medication management (dated 2/10/2020]. Corresponding interventions included; Attempt non-pharmacological interventions and observe effectiveness.	21535		

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21535	Continued From page 25 Interventions include: 1:1 to attempt to address what is upset about. Reasoning has history of not effective. Enable [R1] to return to his room/his comfort zone and time to calm himself down. Observe behavior and attempt to determine pattern, frequency, intensity and triggers. -[R1] uses antipsychotic medication (dated 2/18/21). Interventions included Observe/record target behaviors/symptoms and document per facility protocol. Non-pharmacological interventions included: 1:1 conversation, distraction, ask R1 to help with a specific task, therapy has a peg board that R1 enjoys putting colored pegs into. R1 loves coffee-offer coffee and a cookie and observe effectiveness. -[R1] has episodes of inattention, disorganized thinking related to dementia, psychosis and depression (dated 4/20/21). Corresponding interventions included approach in calm voice, with only one person if possible. R1's physician orders included haloperidol (antipsychotic medication) 2 mg (milligrams) as needed for agitation (with harm to self or others) as needed (PRN) three times a day related to psychosis not due to substance or known physiological condition. R1's Point of Care (POC- nursing assistant documentation) behavior documentation was reviewed from 7/7/21 to 8/4/21; documentation identified behaviors were documented once of shift with check marked boxes identifying which behaviors R1 exhibited during that shift. The documentation did not identify how many occurrences during that shift R1 exhibited the specified behavior nor any documentation of non-pharmacological interventions that were offered or attempted to manage the behavior.	21535		

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21535	Continued From page 26 Behaviors that were identified included, constant walking/pacing, sexually inappropriate behaviors, distressing delusions/hallucinations (speaking to/yelling at individuals), rejection of care, threatening, screaming, cursing at others, biting scratching, grabbing others, striking out hitting or kicking, disruptive sounds/screaming, and wandering. R1's July and August Medication Administration Record (MAR) in conjunction with progress notes were reviewed. PRN haloperidol was administered on the following dates: MAR on 7/2/21 at 8:19 p.m. R1 was administered haloperidol. Progress note indicated a behavior was observed (did not include what behavior). MAR on 7/8/21 at 7:46 p.m. haloperidol was administered. Progress note indicated a behavior was observed (did not include what behavior). Progress note 7/13/21, at 6:40 a.m. indicated R1 was irritable and yelling, "I have to go now!" MAR at 8:45 a.m. haloperidol was administered, progress note indicated a behavior was observed. Progress note at 10:23 a.m. indicated the administration was not effective and R1 continued to holler out at staff. MAR at 7:29 p.m. indicated haloperidol was administered, progress note included, R1 "agitated wheeling around talking about Nazis". MAR on 7/15/21, at 7:00 p.m. haloperidol was administered. Progress note included, "yelling that his recliner chair is moving (chair was sitting stationary). States "the only thing I want is to get the hell out of this place." MAR on 7/16/21, at 5:43 p.m. haloperidol was administered. Progress note included "resident has increased agitation: yelling, screaming, kicking, in and out of the room. Taken to the bathroom which he had a [large bowel	21535		

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21535	Continued From page 27	21535		

movement] on the toilet, administered medication and now sitting in the recliner."
MAR on 7/17/21, at 12:08 a.m. haloperidol was administered. Progress note included "administered for verbal agitation." MAR at 5:00 p.m. haloperidol was administered, progress note included "given prior to behaviors."
MAR on 7/19/21 at 7:37 a.m. haloperidol was administered. Progress note included, "hollering in the dining room. Everybody is going to die. Pacing in the wheelchair."
MAR on 8/4/21 at 7:15 a.m. haloperidol was administered. Progress note included, "[R1] refusing cares, bath. Very anxious, "I'm gonna melt. I can't get in water" Talked that he was dead."

R1's psychiatric telehealth visit note dated 7/20/21, identified R1's diagnoses and behaviors. The following Plan/orders, 1. Will continue current plan of care. 2) Gradual dose reduction of medications are not clinically indicated due to patients psychiatric symptoms as detailed in progress notes. 3) Continue to encourage non-pharmacological strategies such as music and group activities to help with mood stabilization.

During an observation on 8/4/21, at 6:57 a.m. self-propelling in his wheelchair down the hallway; no behaviors were noted. At 7:05 a.m. R1 stated to nursing assistant (NA)-A he was melting. NA-A told R1 "ok, well I think you have a shower today, do you want a shower?" R1 replied "Not right now!, I'm melting". NA-A asked R1 if he needed to use the bathroom, R1 replied "not right now".

During an interview on 8/4/21, at 7:00 a.m. NA-A

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21535	Continued From page 28 stated R1 had behaviors such as refused to be changed when incontinent and physical behaviors toward staff. NA-A stated yesterday he was going to blow everybody up. NA- indicated when R1 had behaviors staff would leave him alone and re-approach him a little later. During a subsequent interview on 8/4/21, at 1:09 p.m. NA-A stated the NA's record behaviors in POC once per shift, and did not document non-pharmacological interventions because there was not a place to document in POC. NA-A stated the number of each behavior was not counted, because that would be too much and there wasn't enough time during the day. NA-A stated they would report if residents had behaviors at the end of the shift to the nurse; nurses were good about asking questions, then the nurse would document in progress notes. During an interview on 8/5/21, at 8:47 a.m. RN-A indicated staff were supposed to document behaviors/interventions in real time to capture the frequency of the behavior to determine trends or if there was improvement or worsening. Interim director of nursing (IDON) confirmed POC did not include an area to document non-pharmacological interventions. IDON indicated the interdisciplinary team reviewed progress notes daily and then evaluated them for behavioral changes; would then update the physician. Vice president of operations (VPO) indicated the facility should be conducting monthly behavior rounds where all the behaviors and interventions are evaluated for effectiveness and/or any improvement/worsening of behaviors. Facility policies PRN psychoactive Medication Guidelines and Adverse Effect Psychoactive	21535		

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21535	Continued From page 29 Medication monitoring did not include documentation requirements and/or guidelines for the facility's behavioral management program.	21535		

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21535	Continued From page 30 Fed tag F758 R18 According to R18's electronic health record (EHR) Admission Sheet and a Medical Provider Telehealth Encounter 5/25/21, included diagnosis of Bipolar I disorder (mood disorder than includes depression and also hyperactivity, euphoria and delusions), recurrent major depressive episodes, panic According to R18's EHR a brief progress note dated 5/25/21, 9:58 a.m. indicated a pharmacy medical record review had been done and there was a recommendation to "review PRN Ativan (antianxiety medication, also called Lorazepam) orders for clarification". According to a hard copy document titled Consultant Pharmacist Recommendation to	21535		

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21535	Continued From page 31 Physician dated 5/25/21, the pharmacist wrote the following in relation to R18's orders: "Recommend discontinuing PRN use of Lorazepam for this resident, or reorder for a specific number of days per the following federal guideline: In accordance with State and Federal Guidelines, revised regulation 483.45(e) psychotropic drugs PRN, orders for psychotropic drugs are limited to 14 days, except when the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Then he or she should document the rational in the Resident's medical record and indicate the duration for the PRN order." The document included a spot to choose either "discontinue this PRN order" or "continue PRN use of Lorazepam for (blank)days, as the benefit outweigh the risk." No response was recorded on the sheet and no corresponding medical provider's signature was observed on the document. A request was made for evidence of a medical provider response to the 5/25/21 pharmacist recommendations. The facility provided the 5/25/21 telehealth encounter notes. The notes included an extensive list of medications for R18, but failed to include any notation of Ativan/Lorazepam. The note failed to indicate the medical provider had reviewed the pharmacist recommendations, and failed to indicate a stop date or duration for any PRN Ativan/Lorazepam. R17's face sheet dated 8/5/21 indicated a diagnosis of vascular dementia without behavioral disturbance and anxiety. R17's Care Plan last revised on 7/12/21, indicated R17 had severe cognitive impairment.	21535		

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21535	Continued From page 32 R17's care plan also indicated R17 used antipsychotic medication related to psychosis, anxiety and behaviors of elopement. Interventions included to attempt non-pharmacological interventions and observe effectiveness. Interventions included: talking about favorite topics while providing cares-his years as a bus driver for [name] School, love to tinker with things when he was at home. Direct away from exit and let him know that [name] isn't here at this time to pick him up. Offer coffee/cookie while he waits for [name]. The care plan also indicated the following interventions: Attempt non-pharmacological interventions and observe effectiveness. Interventions include: talking about favorite topics while providing cares-his years as a bus driver for [name] School, love to tinker with things when he was at home. Also Calmly explain that you will return in a given time and assist with cares. Offer opportunity to walk or wheel to DR [dining room] for coffee and cookie to relax. Physician orders dated 8/5/21 showed R17 was prescribed Lorazepam (used to treat anxiety) 0.5 milligrams every 4 hours as needed (PRN) for restlessness/agitation on 7/6/21. The order lacked a duration for use. R17's record lacked evidence of a physician's evaluation to extend the duration for use of Ativan beyond 14 days. The medication administration record (MAR) showed R17 was given one dose of PRN lorazepam on 7/16/21. Electronic Medication Administration Record (EMAR) note indicated R17 was pulling on other resident's chair constantly with an increased in agitation/anxiety noted. No documentation was found to indicate if any non-pharmacological interventions were	21535		

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21535	Continued From page 33 utilized prior to the administration of PRN lorazepam. During an interview on 08/05/21, at 01:39 p.m., the director of nursing (DON) verified PRN lorazepam is limited to fourteen days, unless a physician documents a rationale to extend the medication. DON then verified there was no documentation to show R17's order for PRN lorazepam was discontinued or reviewed by a physician after fourteen days. Facility Adverse Effect Psychoactive Medication Monitoring Policy, last revised 9/2020, did not include parameters for monitoring PRN lorazepam every fourteen days. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21535		