DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 8, 2025

Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

RE: CCN: 245563
Cycle Start Date: March 19, 2025

Dear Administrator:

On May 7, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2025

Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

RE: CCN: 245563
Cycle Start Date: March 19, 2025

Dear Administrator:

On March 19, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 19, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 19, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/17/25 through 3/19/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 3/17/25 through 3/19/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/1/25

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

Electronically Signed | 04/07/2025

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

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F 641	Continued From page 1 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect range of motion status for 2 of 17 residents (R2, R29) who were in the sample. Findings include: R2: R2's Physical Therapy Evaluation and Plan of Treatment dated 11/19/24, identified R2 impaired ROM in both upper and lower extremities. R2's admission Minimum Data Set (MDS) dated 11/26/24, R2's functional range of motion (ROM) identified R2 had no limitations of range of motion in either upper or lower extremities. Diagnoses included multiple sclerosis and quadriplegia. R2's Mobility Assessment-V2 dated 2/26/25, identified R2 had contractures present and was unable to extend his left elbow past 90 degrees. Bilateral knees and ankles had poor ROM. R2's quarterly MDS dated 2/26/25, R2 was dependent with all areas of activities of daily living, required a mechanical lift to transfer and was unable to ambulate. R2's functional RO) identified R2 had no limitations of range of motion in neither upper or lower extremities. Diagnoses included multiple sclerosis and quadriplegia. R2's care plan revised 2/27/25, identified R2	F 641	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. It is the policy of Green Pine Acres to provide comprehensive assessments in accordance with CFR 483.20 to ensure that each assessment accurately reflects the resident□s status. Green Pine Acres' MDS 3.0 Policy has been reviewed. Policy and Procedure for Assessments for Functional Limitation in Range of Motion has been created. MDS Coordinator and RN Unit Managers have been educated on the intent of Section GG10115. Staff education will include understanding the intent of GG10115 to determine whether functional limitation in range of motion (ROM) interferes with the resident□s activities of daily living or places them at risk of injury. An individualized care plan will address possible reversible causes such as deconditioning and adverse side effects of medications or other treatments.	

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F 641	Continued From page 2 required a restorative nursing program. R2 had contractures to their lift elbow extension, right elbow flexion, and tight overall tone and was at risk for developing additional contractures. Staff were directed to complete passive ROM alternating between upper and lower extremities every other time. During observation on 3/19/25, at 10:43 a.m. R2 was lying on his right side while staff performed a dressing change to his left buttock area. R2 had difficulty moving his upper extremities and was unable to move his lower extremities without assistance. R2's fingers had poor dexterity and limited ROM due to stiffness and contractures. R29: R29's care plan revised 12/5/23, identified R29 had a decline in mobility with limited ROM in right ankle. R29 required a restorative nursing program due to a risk for contractures. Staff were directed to complete active ROM exercises to her lower and upper extremities and transfers to maintain strength. R29's Mobility Assessment-V2 dated 12/27/24, identified R29 had limited ROM to her right shoulder. R29's right elbow had moderate ROM and R29 had right ankle inversion with moderate ROM. R29's quarterly MDS dated 12/27/25, identified R29 required partial to maximum assistance with most ADL's and was dependent with transfers and mobility. R29's functional ROM identified R29 had no limitations of range of motion in either upper or lower extremities. Diagnoses included cerebral infarction, polyosteoarthritis, and	F 641	A modified MDS will be completed for R2 and R29 to correct GG0115. Audits of MDS for all residents will be conducted to determine if GG0115 of MDS has been completed correctly. If changes are necessary, a modified MDS will be completed. The new procedure will be implemented, and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will monitor compliance with the procedure by auditing MDS for compliance and care planning for functional limitation in range of motion. Audits will be performed once weekly x4 weeks, monthly x2 months, and quarterly X2 until compliant. Findings of original audit will be brought to QA meeting and reviewed 5/21/2025. The facility alleges that it will be in substantial compliance with the standard indicated by 5/1/2025	

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F 641	Continued From page 3 epileptic spasm. R29's Occupational Therapy Evaluation and Plan of Treatment dated 4/17/24, identified R29 had impaired ROM in her right upper extremity. During observation on 3/17/25 at 1:23 p.m. R29 was observed seated in a wheelchair in her room. R29 was leaning heavily to right side and her legs and feet were not positioned fully on the wheelchair foot rests. R29 was unable to lift her arms or her legs to correct her position and rang for staff assistance. During interview on 3/19/25, at 2:24 p.m. licensed practical nurse (LPN)-A stated she completed the MDS assessments for all the resident's residing in the facility. LPN-A reviewed the resident's mobility assessment to determine each resident's upper and lower extremity ROM. LPN-A thought she may have been reading the MDS question related to a resident's ROM incorrectly. She coded the resident with impaired ROM only if there was a potential for injury with movement. Now in reviewing the MDS ROM section she could see R2 and R29's MDS were coded incorrectly. When interviewed on 3/19/25, at 3:12 p.m. the director of nursing (DON) stated she did not agree R2 and R29 had full ROM of all their extremities. If both therapy and the mobility assessments identified a resident had impaired ROM in any of their extremities, then the MDS should reflect that. It was important to have the ROM limitations correctly identified on the MDS to account for the resident need for assistance with ADLs.	F 641		

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F 641	Continued From page 4 The facility policy MDS 3.0 Policy Procedure dated 5/1/24, identified the facility would complete a comprehensive assessment of the resident needs. The assessment would include a resident's physical functional status, ability to perform activities of daily living, and the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities. The MDS staff would encode accurate information into the MDS. The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, identified a purpose to offer clear guidance on how to use (i.e., code) the RAI which was divided in multiple sections. The manual outlined, "Section GG: Functional Abilities," which directed an intent to determine whether functional limitation in range of motion (ROM) interfered with the resident's activities of daily living or placed them at risk of injury. The manual outlined the item coded for the presence or absence of functional limitation related to ROM, and thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Coding instructions included to code 0 if resident had full functional range of motion on the right and left side of upper/lower extremities, code 1, impairment on one side if resident had an upper- and/or lower-extremity impairment on one side that interfered with daily functioning or placed the resident at risk of injury, and code 2, impairment on both sides, if resident had an upper- and/or lower_extremity impairment on both sides that interfered with daily functioning or placed the resident at risk of injury.	F 641		

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F 689	Continued From page 5	F 689		
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 ensure the use of motion sensor pager devices were assessed for range upon implementation and when identified the sensor did not alert staff to movement as intended for 1 of 2 residents (R60) reviewed for falls. Findings include: The undated 433 CMU Manufacturer Instructions identified the range of the monitors were 150 to 300 feet; however, environmental factors such as concrete or brick walls and heavy electrical equipment could affect the range. The systems relied on technology which was subject to physical and environmental considerations transmitter would not be 100% accurate if it was out of range. It was the end users responsibility to make sure the product was used correctly and within range. The device was intended as an adjunct to good care giving practices and not a substitute for proper staffing and management practices. It was commended all staff received proper training and the device tested daily. The device was not meant to replace direct patient	F 689	It is the policy of Green Pine Acres to ensure that a residents environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents in accordance with CFR 483.25. Green Pine Acres has updated their Alarm Policy to assess and set limitations for each resident regarding motion sensors and each resident s care plan will state individual limitations.Completed 4/7/2025 R60 has expired. All other residents using the motion sensor will be assessed and care plans will be updated with limitations clearly stated. Completed 4/7/2025 All staff will be educated regarding the updated Alarm Policy and use of motion sensor devices and assessing and care planning for all alarm devices. The new procedure will be implemented, and the plan of correction will be	5/1/25

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F 689	Continued From page 6 supervision, adequate staff training and testing of the system before each use. R60's quarterly Minimum Data Set (MDS) dated 12/4/24, identified R60 had moderately impaired cognition. R60 required moderate assistance with dressing, grooming and transfers and maximum assistance with toileting hygiene. R60 was frequently incontinent of bowel and bladder. Diagnoses included dementia, heart disease, and anxiety. R60's Fall Risk Assessment dated 12/4/24, identified R60 had a history of multiple falls within the last six months. R60 required assistance of one to transfer but would still self-transfer which often resulted in her falls. R60 had a sensor pad on her bed and a sensor boxy in the bathroom doorway to alert staff. The assessment lacked any evidence the alarm box ranges were individually assessed for distance to ensure the alarm functioned as intended, to alert staff to R60's movement. R60's medical record lacked any assessment for alarm box ranges in relation to the sensor to ensure the alarm functioned as intended, to alert staff to R60's movement. R60's care plan revised 12/24/24, identified R60's need for assistance with activities of daily living (ADLs) and R60's mobility fluctuated due to cognition and/or fatigue. A goal was identified to avoid complications with mobility such as falls, injuries or decline. An intervention included a sensor box on R60's bathroom door and directed staff to carry the alarm box (that would alert if R60 attempted to enter the bathroom). The care plan did not identify any how far staff could be	F 689	integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will monitor compliance with the policy by auditing residents care plans who are using any alarm devices. Audits will be performed once weekly x4 weeks, monthly x2 months, and quarterly X2 . Findings of original audit will be brought to QA meeting and reviewed 5/21/2025. The facility alleges that it will be in substantial compliance with the standard indicated by 5/1/2025	

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F 689	Continued From page 7 with the alarm box to ensure the proper functioning of the alarm. R60's Fall Investigation Worksheet dated 8/26/24, identified R60 had an unwitnessed fall and was found on the floor in the bathroom. The bathroom alarm was in place and trained medication assistant (TMA)-A had the alarm box in her pocket. Nursing assistant (NA)-A had taken R60 to her room following supper in the dining room and secured the call light with in R60's reach. R60 had removed the call light and attempted to self transfer to the bathroom and fell. TMA-A reported the alarm box for the bathroom motion sensor had not sounded an alert. The root cause of the fall was determined to be the need to toilet and the intervention to assist R60 to the bathroom after supper was implemented. Batteries were changed to sensor box and alarm. The investigation worksheet lacked evidence an investigation was conducted to determine why the bathroom sensor alarm had failed to alert when R60 entered the bathroom. R60's CNA Fall Worksheet dated 12/22/24, identified R60 had an unwitnessed fall and was found on the floor in the bathroom. R60 stated she had been trying to go to the bathroom. Fuzzy socks and slippers were determined to have contributed to the fall. The worksheet lacked any further investigation into whether the alarms sounded as intended, and if not, any investigation into why the alarm did not sound as intended. During interview on 3/17/24, at 7:24 p.m. NA-B stated R60 would try to take herself to the bathroom a lot. R60 had a motion sensor in her bathroom door and they could usually catch her before she fully got out of her wheel chair. It had	F 689		

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F 689	Continued From page 8 not alarmed when she fell in the bathroom on 12/22/24. When interviewed on 3/18/25, at 8:31 a.m. NA-C stated R60 had a sensor on her bed and bathroom door to alert staff when she moved. An aide would be assigned to keep the box in their pocket and it would alarm by playing music or a noise loudly if R60 entered the bathroom. If the aide went on break, they would hand it off to someone else. R60 would try to go to bed or to the bathroom herself and she fell a lot because of that. The alarm was not working when she fell on 12/22/24. During interview on 3/18/25, at 9:05 a.m. registered nurse (RN)-A stated R60 did have falls due when trying to self transfer. R60 had a motion sensor on her bathroom door and a nursing assistant carried the receiver box in their pocket. The box would chime or made a musical sound when R60 entered her bathroom. The aide that had the alarm box on 12/22/24, was in the dining room and the alarm did not sound. RN-A stated the aide was not in range for the alarm to sound. During interview on 3/18/25, at 10:06 a.m. NA-D stated she was not aware if there was any range for the alarm and was not aware of it not working. During interview on 3/18/25, at 10:09 a.m. TMA-C stated she was wearing the motion sensor box for a resident this morning. She did not think there was a range where the alarm would not work. If they were to go on break they handed the alarm box to someone else and was not aware of it not working.	F 689		

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	245563	A. BUILDING _____ B. WING _____	03/19/2025

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F 689	Continued From page 9	F 689		

During interview on 3/18/24, at 10:23 a.m. NA-E stated the motion sensor alarm had always worked for her when she had it and was not aware of any ranges.

During interview on 3/18/25, at 11:07 a.m. TMA-D stated she had the alarm on 12/22/24, when R60 fell. TMA-D stated she had been wheeling another resident into the dining room and setting her breakfast up when she received a call over the walkie asking who had R60's alarm. TMA-D ran to R60's room but she had already fallen. The alarm had not sounded at all. TMA-D had been told she was out of range of the alarm for it to sound. That was the first time she had ever heard there was a range to the alarm box. When she had started down to R60's room in response to the call on the walkie that she had fallen, the alarm started blaring loudly, so she did not feel the batteries were low.

A joint interview was conducted on 3/18/25, at 11:31 a.m. with the director of nursing (DON) and the administrator. The DON stated she had gotten a call at home regarding the fall and was told the alarm was working and the aide had it on their person. The aide was in the kitchen and the DON thought there was a distance limit on the alarms but was not sure what the footage was. The alarm did sound when the aide entered the hallway, so may have been a delay of a couple of seconds. The DON did not know the range of the motion sensors to the alarm box and looked it up on the website, which indicated the range was 300 feet. Both the DON and the administrator stated they had never tested the range of the motion sensor alarm and thought it would be difficult as the nursing assistants moved through out the halls. The alarm was not investigated or

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F 689	Continued From page 10 tested following R60's fall. On 3/18/25, at 12:20 p.m. the DON placed the motion sensor alarm in R60's former room and called to the nursing assistant on the walkie who had the alarm box. The NA stated she was in the dining room assisting a resident. The DON activated the alarm in R60's room and the NA reported the alarm box did not sound. The DON stated there must be to many walls between the alarm box and motion sensor. The administrator stated the alarm did work and the care plan was followed but it was out of range. During telephone interview on 3/18/25, at 1:09 p.m. the manufacturer of the Wireless Motion Sensor Smart Caregiver Fall Prevention and Anti-wandering Alarm help desk, (MHD)-C stated the alarms were used in quite a few nursing homes. MHD-C stated the determining factor of the range of the sensor was what was between the sensor and the alarm box. The sensor used radio waves and concrete, brick, metal, electrical would all effect the range. The typical range was 150 to 300 feet, but it would depend on what was directly in between the sensor and the alarm box. The absolute maximum distance was 300 feet and that would be if the alarm box and the sensor were in direct line of site. The only way to know the range of how far an alarm will reach from where you placed the sensor was to test it. It was not difficult to test the range. The motion sensor would be placed to where you wanted it and then someone with the alarm box would go a distance away and keep moving away a distance until the alarm box no longer picked up the sensor. A follow up joint interview was conducted on 3/19/25, at 3:54 p.m. with the DON and	F 689		

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F 689	Continued From page 11 administrator. The DON stated she did not work at the facility at the time of R60's first fall and could not say what type of investigation was done to determine the cause of the fall or if the motion sensor was investigated. The DON did not know what assessment was completed to determine the motion sensor alarm was appropriate. It would be hard to determine the range of the sensor, it would be different for each resident. The administrator stated the staff were aware the motion sensors were not a fool proof thing and knew there were limitations to the alarms. The sensors were effective and they could not possibly identify where/if there were dead spots for each resident, as the ranges could change. The facility policy Resident Alarms dated 2/6/25, identified the facility would establish and utilize a systematic approach for the safe and appropriate use of resident alarms, including efforts to identify risk, evaluate and analyze risk, implement interventions to reduce risk and monitor for effectiveness of the interventions and modifying interventions when necessary. When alarms were utilized, additional monitoring would be provided, including but not limited to verifying the alarms were used in accordance to the care plan, working properly and monitoring for adverse consequences. Each resident would be assessed for fall and elopement risk on admission and periodically thereafter. Medical symptoms would be identified and documented in the medical record. Information would come from the medical history, physical exam or individual observation. When alarms were in use or under consideration, risks of adverse consequences related to alarms would be identified.	F 689		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/08/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Green Pines Acres 1964 Main Building 1-story, partial basement Type II (111) 1969 Addition 1-story, no basement Type II (111) 1996 Administration building and connecting link 1-story, no basement Type V (111) separated with 2-hour rated fire barrier 1999 Laundry addition 1-story, no basement Type II (111) 2004 Kitchen addition 1-story, no	K 000		

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K 000	Continued From page 2 basement Type II (111) The building is divided into 4 smoke zones by 30 minute and 90 minute fire barriers. Full automatic sprinkler systems with quick response heads Fire alarm system with smoke detectors in the corridor system, in all common areas and is monitored off site and has automatic fire department notification The facility has a capacity of 65 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		5/1/25

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K 222	Continued From page 3 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with NFPA 101, 1012 Edition, chapters 7.2.1.6.1.1 and 19.2.2.2.4 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. This deficient finding could have a widespread affect on the residents and staff of this facility. Findings Include: On 03/19/2025, between 10:00 A.M. and 12:30 P.M., based on observation and interview of the staff present, the delayed egress assembly installed on the door of the West Wing failed to open in the allowable time. The alarm took approximately 5 seconds to engage and the total lock release time took 22 seconds. An interview with the Maintenance Director confirmed this deficient finding at the time of the survey.	K 222	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. The delayed egress door on West Wing has been adjusted to open in 15 seconds according to NFPA 101 1012 Edition, Chapter 7.2.1.6.1.1 guidelines. Completed 4/7/2025 All delayed egress doors have been checked to ensure that all doors open in 15 seconds. If necessary, all doors have been adjusted to meet NFPA 101 guidelines. Completed 4/7/2025 The Maintenance Director will educate all maintenance staff doing door checks to ensure that the doors open within 15 seconds once pressure is applied. Egress door check list will be updated to provide a detailed description of what each door check should include. Maintenance Director or designee will audit door checks weekly x4 weeks, monthly x2 months, until compliance. Findings of original audit will be brought to QA meeting and reviewed 5/21/2025.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101	K 293		5/1/25

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K 293	Continued From page 5 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1, 7.10.6.2 and 19.2.10 This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 03/19/2025, between 10:00 AM and 12:30 PM, it was revealed by observation that there was an exit sign mounted on a wall, mid-section with no directional arrow to show occupants the correct direction of travel in the event of an emergency. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. The exit sign on West Wing has been replaced with an exit sign that has directional arrows to show occupants the correction direction of travel in the event of an emergency. Completed 3/20/2025 All exit signs that do not clearly show the direction of travel in the event of an emergency have been replaced to meet NFPA 101 (2012 edition) section 7.10 standards. Completed 3/20/2025 Administrator or designee will audit exit signs during construction or replacement of exit signs.	

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K 293	Continued From page 6	K 293	Deficient findings during survey will be brought to QA meeting and reviewed 5/21/2025.	
K 355 SS=F	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 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 properly inspect fire extinguishers per 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 7.1.1, 7.2, 7.2.1.2, 7.2.4. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 03/19/2025, between 10:00 AM and 12:30 PM, it was revealed by observation, that there were several fire extinguishers in the Maintenance Office that were not properly secured. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 355	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. The portable fire extinguishers in the Maintenance Office that were not properly secured have been removed. Completed 3/20/2025 All portable fire extinguishers that are not in use will be secured in a cabinet in the maintenance room and not left unsecured. Completed 3/20/2025 Administrator or designee will audit maintenance office monthly X 6 to ensure compliance. Findings of first audit will be	5/1/25

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K 355	Continued From page 7	K 355	brought to QA meeting and reviewed 5/21/2025.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. These deficient findings could have an widespread impact on the residents within the facility. Findings include: On 03/19/2025 between 10:00 AM and 12:30 PM,	K 362	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance.	5/1/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 362	Continued From page 8 it was revealed by observation that there two penetrations in the firewall of the mechanical room located off of the main egress corridor.. An interview with the Maintenance Director verified these deficient finding at the time of discovery.	K 362	The penetrations in the firewall of the mechanical room have been filled with fire caulking instead of mineral wool. The fire caulking meets the standard of NFPA 101 (2012 edition), Life Safety Code. Completed 3/20/2025 All penetrations have been checked to ensure that all penetrations have been properly sealed with fire caulking to meet NFPA 101 guidelines. Completed 4/7/2025 After any contractor work maintenance director or designee will audit to make sure that penetrations have been sealed. Administrator or designee will audit fire walls monthly X 6 to ensure compliance. Findings of first audit will be brought to QA meeting and reviewed 5/21/2025.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping 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:	K 511		5/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2025**

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GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**

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K 511	Continued From page 9 Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/19/2025, between 10:00 AM and 12:30 PM, it was revealed by observation that the electrical panel located in the utility rooms were not secured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. Electrical panels in utility rooms have been secured according to NFPA 99 (2012 edition). All electrical panels that are not behind a secure locked door will be locked. Completed 3/20/2025 Administrator or designee will audit electrical panels monthly X 6 to ensure compliance. Findings of first audit will be brought to QA meeting and reviewed 5/21/2025.	
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 (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	K 920		5/1/25

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	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2025**

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K 920	Continued From page 10 (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 maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/19/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that there was a multi-plug adapter being used to power several items in the Maintenance Office. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 920	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. The facility will maintain power cords according to NFPA 99 and NFPA 70. The Multiple -plug adapter has been removed from maintenance room. Completed 3/20/2025 A facility inspection will be completed for all electrical cords, power strips, extension cords and multiple plug adapters. Any cords not used in accordance with the codes NFPA 99 & NFPA 70. Facility will educate all staff on the usage of power strips, electrical cords and multi plug adapters. Information will include	

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	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2025**

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K 920	Continued From page 11	K 920	hazards and proper handling techniques. Administrator or designee will audit the use of electrical cords monthly X 4 to ensure adherence to K920 requirements and maintaining proper usage. Findings of first audit will be brought to QA meeting and reviewed 5/21/2025.	