DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2023

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

RE: CCN: 245536
Cycle Start Date: June 15, 2023

Dear Administrator:

On June 15, 2023, 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by September 15, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 15, 2023, (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) / 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 electronic 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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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July 11, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: IWME11

Dear Administrator:

The above facility was surveyed on June 11, 2023, through June 15, 2023, 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:

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

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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@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 06/15/2023

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 June 12 - 15, 2023, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		7/3/23

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

Electronically Signed | 07/21/2023

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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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed during documentation review that no 36 month - 4 hour load bank documentation was presented for review. 2. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed during documentation review that the annual servicing vendor report had identified that the generator battery was in need of replacement. Visual inspection of the battery confirm the battery had not yet been replaced. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	E 041	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 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. In continuing compliance with E 041, Electrical Systems - Essential Electric System. The Green Lea Senior Living Facility corrected the deficiency by having 3rd party vendor perform a 4- hour load bank and replacing the battery to the Emergency Generator. The Maintenance Director was educated by Regional Maintenance support to ensure that any concerns brought up by the 3rd party inspector for the emergency Generator are addressed in a timely manner. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be	

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E 041	Continued From page 4	E 041	sent to the Administration after the review.	
F 000	INITIAL COMMENTS On June 12, 2023 through June 15, 2023, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no deficiency issued. H55362717C (MN00091563) 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the resident and determine safety for self-administration of medications (SAM) for 2 of 2 residents (R16 and	F 554	Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement	7/20/23

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F 554	Continued From page 5 R28) reviewed for SAM. Findings include: R16's significant change Minimum Data Set (MDS) dated 4/15/23, indicated R16 was cognitively intact and was diagnosed with non-ST elevated myocardial infarction (type of heart attack), type 2 diabetes mellitus, hypertension (high blood pressure), coronary artery disease and was independent with most activities of daily living (ADL's). During an interview on 6/12/23, at 3:23 p.m., R16 stated he was able to self-administer all his medication except his nitroglycerin. R16 stated he would like to self-administer his nitroglycerin and had requested to do so back in December of 2022, after an incident where he had chest pain and waited fifty minutes before he received the nitroglycerin. R16 stated he was told he could not self-administer the nitroglycerin but was never given a reason to why not. R16's signed physician orders dated, 12/5/22, indicated R16 could self-administer medications after set-up. R16's care plan dated, 5/1/23, lacked evidence R16 was assessed for SAM. R28's MDS assessment dated 5/20/23, indicated R28 was cognitively intact and was diagnosed with cerebrovascular accident (stroke), hypertension (high blood pressure), heart failure and required substantial assistance with most ADL's. During an observation on 6/12/23, at 2:43 p.m.,	F 554	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 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. In continuing compliance with F 554, Resident Self-Admin Meds-Clinically Appropriate, Green Lea Senior Living corrected the deficiency by reviewing R16 preferences on self-administration of nitroglycerin. This has been reviewed with R16 physician. Medication will be kept in the medication cart. A nursing assessment has been completed on 07/17/2023. Follow up with R16 regarding self-administration occurred on 07/17/2023. R28 eye drops were removed from his room as of 6/14/2023. R28 has been assessed for self-administration and is deemed not appropriate. Resident and responsible party have been reeducated. Audit completed by Director of Nursing on 7/17/2023 of all resident rooms to insure there were no unsecured medications. At this same time, residents that were cognitively intact with BIMS of 13-15 were interviewed regarding their desire to	

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F 554	Continued From page 6 one bottle of clear eye triple relief eye drops was on R28's bedside table. An expired (12/21) bottle of naphcon-a eye drops (used to relieve minor eye redness and/or itching) was on R28's nightstand. During an interview on 6/13/23, at 5:43 p.m., R28 stated he self-administered both eye drops for dry eyes. R28 stated staff was aware that he had the eye drops and used them regularly. R28's current physician orders lacked orders for triple relief eye drops and naphcon-a eye drops. R28's care plan dated, 5/1/23, lacked evidence R28 was assessed for SAM. During an interview on 6/14/23, at 9:44 a.m., trained medication aide (TMA)-A stated the nurses decided which residents could self-administer medications and would put an order in the resident's electronic health record (EHR). TMA-A stated R28 could self-administer eye drops and R16 could self-administer medications after set up. During an interview on 6/14/23, at 9:47 a.m., licensed practical nurse (LPN)-A stated if a resident requested to self-administer medications a nurse would complete the self-administration assessment and obtain physician orders which indicated what medications the resident could or could not self-administer. During an interview on 6/14/23, at 1:45 p.m., with the director of nursing (DON), registered nurse (RN)-A and regional nurse consultant (RNC), the DON stated that the self-administration assessment was completed when a resident	F 554	self-administer medication. MDSC was educated on Self-Administration of Medication Policy and ensuring care plans are updated to reflect self-administration status by the Director of Nursing on 06/28/2023. To correct the deficiency and to ensure the problem does not recur all certified nursing assistants were reeducated on 6/20/2023 and nurses/trained medication aides on 6/28/2023 on the policy and procedure for medication storage and self-administration of medication by the Director of Nursing. The Director of Nursing and/or designee will complete audits of resident rooms for unsecured medication and will interview cognitively intact residents with BIMS of 13-15 about their desire to self-administer medications weekly for 4 weeks, monthly for 2 months, and randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 3 residents with self-administration for assessment and care plan completion weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. As part of Green Lea Senior Living ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the communitys QA Process.	

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	245536	A. BUILDING _____ B. WING _____	C 06/15/2023

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 554	Continued From page 7 requested to SAM. DON stated the self-administration assessment and physician orders would be specific to what medications the resident could or could not self-administer. - RNC stated the self-administration assessment should be re-assessed quarterly, annually and with significant changes. - Both the DON and RN-A stated it was their policy that residents could not store medications in their rooms. -RNC stated that a resident could store medications in their room, but it would need to be stored in a locked box. - RN-A stated R28 was not able to self-administer his own medications, including eye drops. - DON confirmed R16 was not assessed for SAM. - DON confirmed R28 was not assessed for SAM. DON also confirmed R28 did not have physician orders to receive or self-administer either eye drops. -At 2:01 p.m., DON removed both eye drops from R28's room. A facility policy Medication Self Administration Safety Screen and/or Self Administration revised 2018, indicated the medication self-administration safety screen is only completed if the resident requested to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. Evaluation and approval for self-administration of medications would be based on the medication self-administration safety screen. The medication self-administration safety screen would be completed prior to the resident initiating self-administration of medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing evaluation should occur at	F 554		

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F 554	Continued From page 8 a minimum of quarterly. The determination would include whether the resident could self-administer medications unsupervised, with supervision or was not safe to administer medications. A physician order would be obtained indicating which medications the resident may self-administer and with or without supervision.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		7/20/23

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F 561	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up and assess a resident who requested to self-administer nitroglycerin medication for 1 of 1 resident (R16) reviewed for choices. Findings include: R16's significant change Minimum Data Set (MDS) dated 4/15/23, indicated R16 was cognitively intact and was diagnosed with non-ST elevated myocardial infarction (type of heart attack), type 2 diabetes mellitus, hypertension (high blood pressure), coronary artery disease and was independent with most activities of daily living (ADL's). During an interview on 6/12/23, at 3:23 p.m., R16 stated he would like to self-administer his nitroglycerin and had requested to do so back in December of 2022, after an incident where he had chest pain and waited fifty minutes before he received the nitroglycerin. R16 stated he was told he could not self-administer the nitroglycerin but was never given a reason to why not. R16's signed physician orders dated 12/5/22, indicated R16 could self-administer medications after set-up. Physician orders did not indicate that R16 could not self-administer nitroglycerin. R16's care plan dated, 5/1/23, lacked evidence R16 was assessed for SAM. During an interview on 6/14/23, at 9:44 a.m., trained medication aide (TMA)-A stated R16 could self-administer medications after set up.	F 561	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 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. In continuing compliance with F 561, Self-Determination, Green Lea Senior Living corrected the deficiency by reviewing R16 preferences on self-administration of nitroglycerin with R16 and physician. After review and self-administration of medication assessment on 07/17/2023 it has been determined that R16□s medication will be kept in the medication cart and R16 will be allowed to self-administer after set-up by staff. R16 care plan was updated to reflect updated medication administration on 07/17/2023. All other residents potentially affected by this deficient practice were reviewed, assessed, and care plans updated as appropriate. MDSC	

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F 561	Continued From page 10 During an interview on 6/14/23, at 9:47 a.m., licensed practical nurse (LPN)-A stated if a resident requested to self-administer medications a nurse would complete the self-administration assessment and obtain physician orders which indicated what medications the resident could or could not self-administer. During an interview on 6/14/23, at 1:45 p.m., with the director of nursing (DON), registered nurse (RN)-A and regional nurse consultant (RNC), the DON stated that the self-administration assessment was completed when a resident requested to SAM. DON stated the self-administration assessment and physician orders would be specific to what medications the resident could or could not self-administer. - RNC stated the self-administration assessment should be re-assessed quarterly, annually and with significant changes. - Both the DON and RN-A stated they were aware that R16 had requested to self-administer nitroglycerin but stated it was their policy that residents could not store medications in their rooms. - RNC stated that a resident could store medications in their room, but it would need to be stored in a locked box. - DON confirmed R16 had a physician order to self-administer medications after set up, however the order did not specify which medications R16 could self-administer. DON also confirmed R16 was not assessed for SAM. A facility policy Medication Self Administration Safety Screen and/or Self Administration revised 2018, indicated the medication self-administration safety screen is only completed if the resident	F 561	was educated on Self-Administration of Medication Policy and ensuring care plans are updated to reflect self-administration status by the Director of Nursing on 06/28/2023. To correct the deficiency and to ensure the problem does not recur all certified nursing assistants were reeducated on 6/20/2023 and nurses/trained medication aides on 6/28/2023 on the policy and procedure for medication storage and self-administration of medication by the Director of Nursing. The Director of Nursing and/or designee will complete audits or resident rooms for unsecured medication and will interview cognitively intact residents with BIMS of 13-15 about their desire to self-administer medications weekly for 4 weeks, monthly for 2 months, and randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 3 residents with self-administration for assessment and care plan completion weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. As part of Green Lea Senior Living ongoing commitment to quality assurance, the Director of Nursing and/or designee will report	

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F 561	Continued From page 11 requested to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. Evaluation and approval for self-administration of medications would be based on the medication self-administration safety screen. The medication self-administration safety screen would be completed prior to the resident initiating self-administration of medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing evaluation should occur at a minimum of quarterly. The determination would include whether the resident could self-administer medications unsupervised, with supervision or was not safe to administer medications. A physician order would be obtained indicating which medications the resident may self-administer and with or without supervision.	F 561		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		6/22/23

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F 582	Continued From page 12 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice	F 582	Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does	

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F 582	Continued From page 13 (SNFABN) to 2 of 6 residents (R13 and R184) reviewed whose Medicare A coverage ended and then remained in the facility. In addition, the facility failed to provide the required Notice of Medicare Non-Coverage (NOMNC) for 2 of 6 residents (R13 and R183) reviewed whose Medicare A coverage ended and one resident (R13) remained in the facility and one resident (R183) transferred to another facility. Findings include: R13 R13's Medicare Part A skilled Services began on 3/28/23. Last coverage day (LCD) was documented as 5/8/23. Resident remained in the facility. R13's medical record was reviewed and lacked any evidence a SNFABN and/or NOMNC had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. The Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form (CMS-20052) completed by social worker (SW) for R13 indicated this was a facility/provider-initiated discharge when benefit days were not exhausted. This form also indicated a SNFABN was not completed and the NOMNC was completed, however this document was not able to be located. Based on R13's scenario both the SNFABN and NOMNC are required. R183 R183's Medicare Part A Skilled Services began on 1/25/23. LCD was documented as 3/14/23.	F 582	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 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. In continuing compliance with F 582, Medicaid / Medicare Coverage / Liability Notice, Green Lea Senior Living corrected the deficiency by ensuring the Social Worker educated the responsible party of R18 on resident rights including liability notice. R183 is no longer resides at the facility. All residents that experienced a discontinuation of skilled service coverage since 6/1/2023 were reviewed by the facility Business Office Manager and Executive Director, to ensure that they were given an Advanced Beneficiary Notice (ABN) or Notice of Medicare Non-Coverage (NOMNC) and this was properly documented To prevent this from recurring, the Social Worker was educated by the Executive Director on the process for providing residents or responsible parties an ABN / NOMNC and documentation of providing	

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F 582	Continued From page 14 Resident discharged to an assisted living facility (ALF). R183's medical record was reviewed and lacked any evidence a SNFABN and/or NOMNC had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. The Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form (CMS-20052) completed by SW for R183 indicated this was a facility/provider-initiated discharge when benefit days were not exhausted. On this form the SW indicated the SNFABN was not completed. The SW indicated the NOMNC is not known to have been completed as they are not able to find a copy. Based on R183's scenario the NOMNC is required. R184 R184's Medicare Part A Skilled Services began 12/6/22. LCD was documented as 1/16/23. Resident remained in the facility. R184's medical record was reviewed and lacked any evidence a SNFABN and/or NOMNC had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. The Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form (CMS-20052) completed by SW for R184 indicated this was a voluntary/self-initiated discharge. On this form the SW indicated the SNFABN was not completed. A copy of the NOMNC was provided however was not signed by the resident or resident representative (RR). Based on R184's scenario the SNFABN is required.	F 582	the ABN / NOMNC on 6/22/2023. The Executive Director and/or designee will audit resident□s weekly who had a discontinuation of skilled services, for 12 weeks, to ensure ABNs/NOMNCs were provided timely and documented beginning the week of 7/10/2023. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community□s QA Process.	

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F 582	Continued From page 15 During an interview on 6/14/23, at 2:46 p.m. SW verified she was responsible to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN CMS10055) and Medicare non-coverage (NOMNC CMS10123) notices within the facility. SW verbalized her awareness that a new form is coming out on the 30th of the month and presented the laminated guidelines to determine which forms are required based on the resident discharge scenario. SW stated she cannot find the documents for R13 or R183 but she recalls completing them. Regarding R184 not having the required SNFABN SW stated it was "my mistake". A Beneficiary Notice policy was requested but was not provided.	F 582		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bathing assistance was provided for 1 of 4 resident (R10) reviewed for activities of daily living (ADL's). Findings include: R10's annual Minimum Data Set (MDS) dated 4/25/23, indicated R10 has mildly impaired cognition and was diagnosed with cardiomegaly (enlarged heart), obesity, hypertension (high	F 677	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	7/20/23

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F 677	Continued From page 16 blood pressure), chronic kidney disease, and required moderate assistance with bathing. R10's care plan updated on 5/1/23, indicated R10 required an assist of one staff with shower twice weekly and as necessary. During an observation on 6/13/23 at 12:08 p.m., R10 had a strong body odor notable from the hallway outside his room. R10's electronic health record (EHR) indicated he received a shower on 6/6/23, refused a shower on 6/9/23 and "not applicable" was documented for his shower scheduled on 6/13/23. During an observation and interview on 6/14/23, at 9:32 a.m., R10 had strong body odor present. R10's polo shirt had dried food stains all down the front and left pant leg had dried crusted brown material present. R10 stated he was not offered a shower the previous evening and would have liked to of had one. During an interview on 6/14/23 at 9:47 a.m., licensed practical nurse (LPN)-A stated when a resident refused a shower the nurse would document it in the resident's EHR. LPN-A stated she was unsure what not applicable meant in the EHR but assumed it meant the resident was not given the shower. LPN-A stated if a shower was not given the resident would have to wait until their next scheduled shower day to receive one. During an interview on 6/14/23 at 9:59 a.m., nursing assistant (NA)-B confirmed that R10 had a strong body odor present and had visibly soiled clothing on. NA-B also confirmed R10 should have had a shower the prior evening but did not	F 677	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. In continuing compliance with F 677, ADL Care Provided for Dependent Residents, Green Lea Senior Living corrected the deficiency by ensuring R10 received a bath on 06/14/2023. Bathing preferences were discussed with R10 and R10 prefers bath bi-weekly in the evenings on Tuesdays and Fridays. If R10 refuses bath, staff will document refusal and bath will be rescheduled for next available day per R10 request. All like residents were interviewed by the Director of Nursing on 7/20/2023 to assess their bathing preferences. To correct the deficiency and to ensure the problem does not recur all staff were educated on 6/20/2023 for certified nursing assistant and on 6/28/2023 nurses and trained medication aides on residents bathing preferences by the Director of Nursing. The Director of Nursing and/or designee will audit bathing completion for 5 residents 5 days a week for 4 weeks, then weekly for 2 months, and then randomly to ensure continued compliance. As part of Green Lea Senior Living ongoing commitment to quality assurance,	

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F 677	Continued From page 17 get it because they only had two NA's working. NA-B stated resident showers were frequently missed on the evening shift and the day shift did not have time for extra showers so the residents would have to wait until their next scheduled shower day to receive one. During an interview on 6/14/23 at 1:45 p.m., with the director of nursing (DON) and registered nurse (RN)-A, the DON stated the expectation was for residents to receive their baths every week. If a bath was missed the nurse should be notified and should make note of the missed bath and arrange for the resident to receive a bath the next shift. DON stated the resident should not have to wait until their next scheduled shower day. Both the DON and RN-A confirmed R10 had a strong body odor and RN-A stated R10 frequently refused assistance with morning and bedtime cares which was the cause of his body odor. DON stated it was important that R10 received his weekly showers because of his history of refusing daily cares. A facility policy regarding ADL's was requested but not received.	F 677	the Director of Nursing and/or designee will report identified concerns through the communitys QA Process.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		6/29/23

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 06/15/2023

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 732	Continued From page 18 resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently include all licensed nursing staff on the daily nurse staff posting. This had the potential to affect all 33 current residents, their families and visitors. Findings include: During observation on 6/12/23, at 2:15 p.m. the facility nurse staff posting was posted on the wall	F 732	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.	

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F 732	Continued From page 19 next to the nurses office. The posting included the date, direct care nursing staff shifts, numbers, census and total hours worked. During interview on 6/15/23, at 8:31 a.m. the staffing coordinator (SC) stated she was not responsible for updating and posting the nurse staff posting, but rather the nurses. In review of the facility's staff postings and the actual working schedules, it was noted the facility lacked documentation / posting all licensed nurses for a 24 hour period. The facility failed to list the director of nursing (DON) and other corporate nurses who covered the days where licensed coverage and overall staffing numbers would have been low. During interview on 6/15/23, at 10:28 a..m. interim administrator (ADM)-B and training / previous administrator (ADM)-A stated they were not certain if the DON and other corporate nurses assisting in coverage were to be placed on the daily nursing posting. ADM-A stated when the DON and/or corporate nurses are schedule outside or their regular duties, their role is to cover the required 8 hours of licensed nursing and assisting with direct care as needed. During the same interview, with both ADM-A and ADM-B, they stated the facility did not have a policy of daily licensed staff posting.	F 732	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. In continuing compliance with F 732, Posted Nursing Staff Information, Green Lea Senior Living corrected the deficiency by updating the facilities posted nursing staffing form to include the director of nursing□s hours and consulting nursing hours. The facility will keep the posted daily nurse staffing data and the facilities□ actual working schedule for a minimum of 18 months, or as required by State law, whichever is greater. Education has been provided for all relevant staff members on the importance of accurately posting nurse staffing information. The Executive Director and/or designee will review the posted daily nurse staff form daily for 4 weeks beginning the week of 7/10/2023 and then randomly to ensure continued compliance. As part of Green Lea Senior Livings ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community□s QA Process.	
F 851 SS=C	Payroll Based Journal	F 851		7/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 851	Continued From page 20 CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including,	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 851	Continued From page 21 but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently include the facility census on the daily nurse staff posting. This had the potential to affect all 29 current residents, their families and visitors. Findings include: The facility's Staffing Data Submission Payroll Based Journal (PBJ), noted the facility was triggered for survey review of "Low Weekend Staffing" and "Licensed Nurses for 24 hours per day" during the 1st quarter of 2023 for the following dates: Wednesday 10/05/22	F 851	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 procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 851	Continued From page 22 Wednesday 10/12/22 Tuesday 10/25/22 Monday 11/07/22 Sunday 11/13/22 In review of the facility's staff postings and the actual working schedules, it was noted the facility lacked documentation / posting all licensed nurses for a 24 hour period. The facility failed to list the director of nursing and other corporate nurses who covered the days where licensed coverage and overall staffing numbers which would have been low. In review of facility staff schedules and time card entries. provided by the facility for the five dates listed above, corporate / management nurses scheduled to covered required hours for compliance were not recorded on the daily postings not documented on the PBJ reporting system. During interview on 6/15/23, at 10:28 a.m. interim administrator (ADM)-B and training / previous administrator (ADM)-A stated the failed to place the covering corporate / management nurses on the PBJ reporting system. ADM-A stated when the DON and/or corporate nurses are schedule outside or their regular duties, their role is to cover the required 8 hours of licensed nursing and assisting with direct care as needed. During the same interview, with both ADM-A and ADM-B, they stated the facility did not have a policy for reporting licensed staff on the PBJ reporting system.	F 851	maintains it is in compliance with the requirements of participation, or that corrective action was necessary. In continuing compliance with F 851, Payroll Based Journal, Green Lea Senior Living corrected the deficiency by updating the facilities posted nursing staffing form to include the director of nursings and consulting nursing hours hours only if they will be providing direct patient care. The facility will keep the posted daily nurse staffing data and the facilities actual working schedule for a minimum of 18 months, or as required by State law, whichever is greater. Education has been provided for all relevant staff members on the importance of accurately posting nurse staffing information. The Executive Director and/or designee will review the posted daily nurse staff form daily for 4 weeks beginning the week of 7/10/2023 and then randomly to ensure continued compliance. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community□s QA Process.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245536	A. BUILDING: _____ B. WING _____	**6/15/2023**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245536	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/15/2023

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to notify the Office of the long-term care (LTC) Ombudsman of transfer for 1 of 1 resident (R1) reviewed for hospitalization.

Findings include:

R1's annual Minimum Data Set (MDS), dated 3/23/23, identified intact cognition.

R1's progress note, dated 3/23/23, identified increase in pain and swelling posterior below knee. R1 was sent to the emergency department (ED) for evaluation per doctor's order.

Progress note, dated 3/28/23, identified R1 was re-admitted to the nursing home after being hospitalized for severe sepsis with encephalopathy, likely due to a urinary tract infection (UTI).

R1's medical record lacked evidence the LTC Ombudsman had been notified of hospital transfer.

When interviewed on 6/14/23 at 3:35 p.m., licensed social worker (LSW) stated the Admission/Discharge To/From Report was ran monthly and faxed to the Ombudsman. LSW stated the last report that was faxed to the Ombudsman was for February 2023.

The Emergency Notice of Transfer or Discharge and Notice of Bed Hold Policy did not identify the process regarding notification to the Ombudsman.

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 06/15/2023

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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 June 12-15, 2023, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H 55362717C (MN00091563) 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,	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	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 ensure bathing assistance was provided for 1 of 4 resident (R10) reviewed for activities of daily living (ADL's). Findings include: R10's annual Minimum Data Set (MDS) dated 4/25/23, indicated R10 has mildly impaired cognition and was diagnosed with cardiomegaly (enlarged heart), obesity, hypertension (high blood pressure), chronic kidney disease, and	2 830	Corrected.	7/20/23

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2 830	Continued From page 3 required moderate assistance with bathing. R10's care plan updated on 5/1/23, indicated R10 required an assist of one staff with shower twice weekly and as necessary. During an observation on 6/13/23 at 12:08 p.m., R10 had a strong body odor notable from the hallway outside his room. R10's electronic health record (EHR) indicated he received a shower on 6/6/23, refused a shower on 6/9/23 and "not applicable" was documented for his shower scheduled on 6/13/23. During an observation and interview on 6/14/23, at 9:32 a.m., R10 had strong body odor present. R10's polo shirt had dried food stains all down the front and left pant leg had dried crusted brown material present. R10 stated he was not offered a shower the previous evening and would have liked to of had one. During an interview on 6/14/23 at 9:47 a.m., licensed practical nurse (LPN)-A stated when a resident refused a shower the nurse would document it in the resident's EHR. LPN-A stated she was unsure what not applicable meant in the EHR but assumed it meant the resident was not given the shower. LPN-A stated if a shower was not given the resident would have to wait until their next scheduled shower day to receive one. During an interview on 6/14/23 at 9:59 a.m., nursing assistant (NA)-B confirmed that R10 had a strong body odor present and had visibly soiled clothing on. NA-B also confirmed R10 should have had a shower the prior evening but did not get it because they only had two NA's working. NA-B stated resident showers were frequently	2 830		

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GREEN LEA SENIOR LIVING	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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2 830	Continued From page 4 missed on the evening shift and the day shift did not have time for extra showers so the residents would have to wait until their next scheduled shower day to receive one. During an interview on 6/14/23 at 1:45 p.m., with the director of nursing (DON) and registered nurse (RN)-A, the DON stated the expectation was for residents to receive their baths every week. If a bath was missed the nurse should be notified and should make note of the missed bath and arrange for the resident to receive a bath the next shift. DON stated the resident should not have to wait until their next scheduled shower day. Both the DON and RN-A confirmed R10 had a strong body odor and RN-A stated R10 frequently refused assistance with morning and bedtime cares which was the cause of his body odor. DON stated it was important that R10 received his weekly showers because of his history of refusing daily cares. A facility policy regarding ADL's was requested but not received. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21565	Continued From page 5	21565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the resident and determine safety for self-administration of medications (SAM) for 2 of 2 residents (R16 and R28) reviewed for SAM. Findings include: R16's significant change Minimum Data Set (MDS) dated 4/15/23, indicated R16 was cognitively intact and was diagnosed with non-ST elevated myocardial infarction (type of heart attack), type 2 diabetes mellitus, hypertension (high blood pressure), coronary artery disease and was independent with most activities of daily living (ADL's). During an interview on 6/12/23, at 3:23 p.m., R16 stated he was able to self-administer all his medication except his nitroglycerin. R16 stated he would like to self-administer his nitroglycerin and had requested to do so back in December of 2022, after an incident where he had chest pain and waited fifty minutes before he received the nitroglycerin. R16 stated he was told he could not self-administer the nitroglycerin but was never given a reason to why not.	21565	Corrected	7/20/23

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21565	Continued From page 6 R16's signed physician orders dated, 12/5/22, indicated R16 could self-administer medications after set-up. R16's care plan dated, 5/1/23, lacked evidence R16 was assessed for SAM. R28's MDS assessment dated 5/20/23, indicated R28 was cognitively intact and was diagnosed with cerebrovascular accident (stroke), hypertension (high blood pressure), heart failure and required substantial assistance with most ADL's. During an observation on 6/12/23, at 2:43 p.m., one bottle of clear eye triple relief eye drops was on R28's bedside table. An expired (12/21) bottle of naphcon-a eye drops (used to relieve minor eye redness and/or itching) was on R28's nightstand. During an interview on 6/13/23, at 5:43 p.m., R28 stated he self-administered both eye drops for dry eyes. R28 stated staff was aware that he had the eye drops and used them regularly. R28's current physician orders lacked orders for triple relief eye drops and naphcon-a eye drops. R28's care plan dated, 5/1/23, lacked evidence R28 was assessed for SAM. During an interview on 6/14/23, at 9:44 a.m., trained medication aide (TMA)-A stated the nurses decided which residents could self-administer medications and would put an order in the resident's electronic health record (EHR). TMA-A stated R28 could self-administer eye drops and R16 could self-administer medications after set up.	21565		

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21565	Continued From page 7 During an interview on 6/14/23, at 9:47 a.m., licensed practical nurse (LPN)-A stated if a resident requested to self-administer medications a nurse would complete the self-administration assessment and obtain physician orders which indicated what medications the resident could or could not self-administer. During an interview on 6/14/23, at 1:45 p.m., with the director of nursing (DON), registered nurse (RN)-A and regional nurse consultant (RNC), the DON stated that the self-administration assessment was completed when a resident requested to SAM. DON stated the self-administration assessment and physician orders would be specific to what medications the resident could or could not self-administer. - RNC stated the self-administration assessment should be re-assessed quarterly, annually and with significant changes. - Both the DON and RN-A stated it was their policy that residents could not store medications in their rooms. -RNC stated that a resident could store medications in their room, but it would need to be stored in a locked box. - RN-A stated R28 was not able to self-administer his own medications, including eye drops. - DON confirmed R16 was not assessed for SAM. - DON confirmed R28 was not assessed for SAM. DON also confirmed R28 did not have physician orders to receive or self-administer either eye drops. -At 2:01 p.m., DON removed both eye drops from R28's room. A facility policy Medication Self Administration Safety Screen and/or Self Administration revised 2018, indicated the medication self-administration	21565		

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21565	Continued From page 8 safety screen is only completed if the resident requested to do their own medications or some of their own medications such as inhalers, eye drops or actual pills. Evaluation and approval for self-administration of medications would be based on the medication self-administration safety screen. The medication self-administration safety screen would be completed prior to the resident initiating self-administration of medications and with any medication changes, changes in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing evaluation should occur at a minimum of quarterly. The determination would include whether the resident could self-administer medications unsupervised, with supervision or was not safe to administer medications. A physician order would be obtained indicating which medications the resident may self-administer and with or without supervision. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed for self-administration of medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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 _____	**06/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/13/2023. At the time of this survey, GREEN LEA SR 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		07/21/2023

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

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

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K 000	Continued From page 2 by a 2 hour fire separation. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 41 beds and had a census of 33 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=E	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 facility discharge from exits requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.1.1,	K 271	Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement	8/4/23

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K 271	Continued From page 3 7.1.6.3, 7.1.6.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that at the North Exit door the pathway exhibited a vertical drop from door threshold to concrete slab of more than 2 inches creating a trip or fall hazard. 2. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that at the North Exit door the concrete pathway exhibited spalling creating a trip or fall hazard. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 271	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 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. In continuing compliance with K 271, Discharge from Exits. The Green Lea Senior Living Facility corrected the deficiency by having the Maintenance Director level the pathway outside at the NORTH EXIT Door so there is no longer a trip hazard. All other egress exits were inspected to ensure there were no further concerns that would create a trip hazard. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		8/4/23

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K 353	Continued From page 4 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 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, section(s), 5.2.1.1.1, 5.2.1.1.2(2)(5), 5.2.1.2, NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that the sprinkler heads in the Kitchen, inside the Range Hood, and the Dining Room exhibited signs of debris loading	K 353	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 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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K 353	Continued From page 5 2. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that the in the Basement Break Room Storage Closets items were placed and stacked closer than 18 inches to the sprinkler head(s) An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	In continuing compliance with K 353, Sprinkler Systems □ Maintenance and Testing. The Green Lea Senior Living Facility corrected the deficiency by having the Maintenance Director clean the sprinkler heads in the Kitchen, inside the range hood. And the Dining Room which exhibited signs of debris. Also, the area that was identified in the basement breakroom storage closet that had items placed and stacked closer than 18 inches were removed. All other sprinkler heads were inspected to ensure that they did not have debris or items closer than 18 inches to them, any negative findings were fixed by Maintenance Director. The Maintenance Director was educated by Regional Maintenance support. All staff were educated to prevent concerns. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		8/4/23

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K 374	Continued From page 6 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed by observation that testing of the following fire and smoke barrier door assemblies exhibited an air-gap greater than 1/8" that would allow the passage of smoke: Dining Area; North Lobby Area; Activities Area; South Corridor. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	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 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. In continuing compliance with K 374, Subdivision of Building Spaces - Smoke Barrier. The Green Lea Senior Living Facility corrected the deficiency by having all gaps closed to resist the passage of smoke in the Dining Area; North Lobby Area; Activities Area; South Corridor. All other Doors were inspected to ensure that they met the requirements to resist	

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K 374	Continued From page 7	K 374	the passage of smoke, any negative findings were fixed by the Maintenance Director. The Maintenance Director was educated by Regional Maintenance support. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to the Administration after the review.	
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: Based on a review of available documentation and staff interview the facility failed to maintain, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15.2, and NFPA 80 (2010 edition), sections 5.2.1, 5.2.3.1. These deficient findings could have a widespread impact on the residents within	K 761	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	8/4/23

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	245536	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/13/2023**

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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K 761	Continued From page 8 the facility. Findings include: On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation, that door inspections were last completed on 01/29/2022 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	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. In continuing compliance with K 761, Maintenance, Inspection & Testing - Doors. The Green Lea Senior Living Facility corrected the deficiency by having doors tested by Maintenance Director. All other Doors were inspected as required and any negative findings were corrected by the Maintenance Director. The Maintenance Director was educated by Regional Maintenance support to ensure that all doors are inspected at least annually or upon need of repair. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to the Administration after the review.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		8/4/23

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K 918	Continued From page 9 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for	K 918	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	

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K 918	Continued From page 10 Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed during documentation review that no 36 month - 4 hour load bank documentation was presented for review. 2. On 06/13/2023 between 10:30 AM and 2:30 PM, it was revealed during documentation review that the annual servicing vendor report had identified that the generator battery was in need of replacement. Visual inspection of the battery confirm the battery had not yet been replaced. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	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 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. In continuing compliance with K 918, Electrical Systems - Essential Electric System. The Green Lea Senior Living Facility corrected the deficiency by having 3rd party vendor perform a 4- hour load bank and replacing the battery to the Emergency Generator. The Maintenance Director was educated by Regional Maintenance support to ensure that any concerns brought up by the 3rd party inspector for the emergency Generator are addressed in a timely manner. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to the Administration after the review.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		8/4/23

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K 923	Continued From page 11 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 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	K 923	Green Lea Senior Living denies it violated any federal or state regulations.	

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K 923	Continued From page 12 storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.1, 9.3.7.4 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed by observation that exhaust fan in the Med Gas (O2) Storage Room where liquid oxygen transfill occurs was not operational. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	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 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. In continuing compliance with K 923, Gas Equipment - Cylinder and Container Storage the Green Lea Senior Living Facility corrected the deficiency by having the Maintenance Director fix the exhaust fan in the oxygen room. The Maintenance Director was educated by Regional Maintenance support to ensure that all requirements for Oxygen storage is being followed. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to the Administration after the review.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101	K 926		8/4/23

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K 926	Continued From page 13 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1, 11.5.2.3.2(3). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed during documentation review that no documentation was presented to confirm that that medical gas training program is currently in use by the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	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 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. In continuing compliance with K 926, Gas Equipment - Qualifications and Training. The Green Lea Senior Living Facility corrected the deficiency by all staff that handles oxygen trained to safely handle medical gas.	

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K 926	Continued From page 14	K 926	The Maintenance Director was educated by Regional Maintenance support to ensure that all requirements for Oxygen handling training is being followed. A comprehensive life-safety audit is conducted annually by RWL Consulting LLC. The cited findings will be inspected during this review. A written report will be sent to the Administration after the review.	