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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S5BD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 07/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/03/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245536

July 21, 2014

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rr 2 Box 49
Mabel, Minnesota 55954

Dear Ms. Vettleson:

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

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

Effective July 1, 2014 the above facility is certified for or recommended for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 21, 2014

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rr 2 Box 49
Mabel, Minnesota 55954

RE: Project Number S5536023

Dear Ms. Vettleson:

On June 12, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 5, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 21, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 5, 2014, effective July 1, 2014 and therefore remedies outlined in our letter to you dated June 12, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245536	A. Building B. Wing	7/21/2014

Name of Facility	Street Address, City, State, Zip Code
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **07/01/2014**	ID Prefix **F0174** Reg. # **483.10(k),(l)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **07/01/2014**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/01/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/01/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/kfd	07/21/2014	10160	07/21/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/5/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245536	A. Building B. Wing **01 - MAIN BUILDING 01**	7/2/2014

Name of Facility	Street Address, City, State, Zip Code
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**07/01/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/21/2014	25822	07/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/4/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S5BD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 06/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/03/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 12, 2014

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rr 2 Box 49
Mabel, Minnesota 55954

RE: Project Number S5536023

Dear Ms. Vettleson:

On June 5, 2014, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 15, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 15, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 5, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
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:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		7/1/14

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

Electronically Signed | 06/19/2014

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.

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review resident rights during residents stay at the facility. This had the potential to affect 48 of 48 residents residing in the facility. Findings include: During interview on 6/4/14, at 11:50 a.m., R39 had stated, " No " when asked by surveyor does the staff talk about and review the rights of residents in the facility. Document review of the facility resident council minutes dated 3/5/14, 4/2/14 and 5/1/14, revealed residents rights had not been reviewed. During interview on 6/4/14, at 5:00 p.m., activity director had stated I have not reviewed rights at	F 156	The preparation of the following correction for this deficiency does not consitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for tis deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F156 1. R39 and R20 were each given a copy of the Resident's Bill of rights on 6/18/14 and the document was reviewed with	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 156	Continued From page 3 resident council meetings. Activity director had stated social worker would do that. During interview on 6/4/14, at 12:17 p.m., social worker had stated I have not been reviewing resident rights; it should be done at resident council. Social worker had stated if activity director had not been doing it then it has not been getting done. During interview on 6/4/14, at 12:55 p.m., activity director stated I have not been doing on my end in regards to reviewing resident rights and had looked back through resident council meeting minutes dated 7/13 through 5/14, at the time and verified resident rights had not been reviewed. Document review of the facility Tealwood Care Centers Corporate Compliance Manual Residents' Rights & Quality of Life policy date issued 9/1/04, read, "Elements A resident has the right: To be fully informed of his or her rights and all the rules and regulations governing resident conduct and responsibilities during the stay in the facility."	F 156	each of them by the DNS. 2. The Licensed Social Worker (LSW)/Designee will ensure that the entire Residents' Bill of Rights is reviewed with each resident annually or if he or she is unable to comprehend the information, the responsible party throughout the year. 3. On 6/18 the LSW inserviced the Community Life Coordinator on the process of educating residents/responsible parties on the Bill of Rights. 4. An audit will be done monthly by the LSW until substancial compliance to ensure that annually all residents/responsible parties are informaed of the content of the Residents' Bill of Rights. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for Monitoring: LSW/Designee	
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the	F 174		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 174	Continued From page 4 rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain a resident's personal property in a safe manner for 1 of 1 resident (R20) reviewed for personal property. Findings Include: R20 had been admitted on 8/18/09 according to the face sheet. During family interview on 6/3/14, at 5:59 p.m., family member (F)-D had stated R20 had a missing magnifying glass and two rosaries. F-D had stated administrator had been told and had not responded back regarding missing items and then stated they don ' t tell anyone about missing things anymore and had stated rosaries are important to R20. During interview on 6/4/14, at 1:15 p.m.., social worker had stated she was aware of the missing magnifying glass and rosaries, F-D had reported it to her and they had moved R20's waste basket away from tray table so items on tray table would not be able to fall into garbage. At 1:45 p.m., social worker stated she did not know the date of when the magnifying glass and rosaries had been reported missing, no grievance report had been filled out, no documentation had been done regarding missing magnifying glass and rosaries. At 2:30 p.m., social worker verified they had not followed system policy in regards to lost or missing property. Document review of the facility GREEN LEA MANOR HEALTH CARE CENTER policy Lost or Missing Property dated 5/28/09, read, "If item is	F 174	The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F174 #1. R20's misplaced items will be replaced. #2. The facility has established a Lost or Missing Property Tracking Log to track lost or missing items. #3. Staff will be inserviced June 19, 2014	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 174	Continued From page 5 not found 1. Complete a Lost or Missing Property Form & give to Social Services 5. If the item is not recovered within 30 days the resident &/or responsible party for the resident will be notified by Social Services. This will be documented in the resident's Social Services progress notes."	F 174	to review the "Lost and Missing Property" procedure. #4. Social Services will complete audits of the Lost or Missing property Tracking Log once a week times 4 weeks and then monthly. Resident interviews will be completed quarterly and PRN. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for monitoring: Lita Frederickson, LSW	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notice for change of roommate assignments, prior to the change occurring, for 1 of 2 residents (R39) who had a recent room change. Findings include: R39 reported a new roommate had moved in about a month ago without prior notification from the facility during interview on 6/3/14, at 2:08 p.m. Review of R39's record lacked documentation that notification for the roommate change had	F 247	F247 #1. On 6/18/14 Social Services visited with R39 and reviewed Room Change procedure with her and reassured her that she will be notified of room changes in the future. #2. Social Services has been re-educated on the facility Room Change procedure to reflect documentation needed in Social Services notes or Nurses Notes r/t the cause of room change and notification of	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 247	Continued From page 6 been provided. R39's quarterly Minimum Data Set (MDS) dated 5/27/14, identified intact cognition. Review of facility census list indicated R39's roommate had been admitted to the room on 4/30/14. During interview on 6/4/14, at 11:49 a.m. the licensed social worker (LSW)-A stated, "I'm sure I told her but I didn't document it." LSW-A was unable to report date or time notification would have occurred and verified R39 had intact cognition. When interviewed on 6/4/14, at 1:55 p.m. the administrator reported the expectation had been residents were to be notified prior to a room or roommate change and that notification would have been documented. The facility policy titled Room Change, dated 10/09, and included, under number 1 read, "The Social Worker shall speak with the resident and/or resident's representative about the reasons for the room change." Number 7 "If there will be a roommate in the room the resident will be moving to, the social worker/nursing staff will inform the resident that another resident will be moving in."	F 247	new roommate. The facility has established a Roommate Change and Notification Log. Social Services will perform audits of Roommate Change and Notification Log weekly to ensure all notifications have been completed. #3. Social Work will review with DON the changes in procedure. Nurses will be inserviced on June 19, 2014 to review the Room Change procedures. #4. The data collected will be reviewed/discussed at the monthly Quality Improvement meeting for further evaluation, interventions, and ongoing audits. Responsible for Monitoring: Lita Frederickson, LSW	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 250	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet psychosocial needs related to roommate concerns, adjustment to health changes and nursing home placement, coping skills for 1 of 1 resident (R65). Findings include: R65 was admitted to the facility 4/30/14 according to the admission sheet. The care plan dated 6/2/14 listed diagnoses that included: cognitive impairment, stroke with right sided hemiplegia, peripheral vascular disease, heart disease, anxiety, and depression. On 6/13/14 at 2:15 p.m. R65 was observed sitting in a wheelchair and was propelling the wheelchair with her left foot. R65 shared her room with another resident. R65 bed was located next to the bedroom door. On 6/3/14 R65 was observed lying in bed with over-bed light turned on. R65 had a fan blowing directly at her-less than 2 feet from her body. The privacy curtain was pulled between the two residents which fully blocked R65's view through the window. The roommate was not in the room at this time. R65 was interviewed on 6/3/14 at 2:13 p.m. R65 stated she was in the nursing home because she had a stroke. R65 stated she and her roommate did not always get along. R65 liked to stay up late and her roommate liked to go to bed early. R65 liked to have lights on when awake, but the roommate liked to have it dark when she would sleep. R65 stated it was too hot in her room so had a fan in her room. R65 stated she was	F 250	The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F250 #1. In regards to R65, she was offered a room change and accepted the room change on 6/10/14. On 6/12/14 R65 was moved to room 404B. The social worker spoke with R65 on 6/12/14 and 6/17/13 r/t current room and roommate. R65 said she is happy with both. #2. Social Services will follow up with R65 once a week for the next month to ensure she is not experiencing any further problems with a roommate. The results of the interviews will be shared at the next Quality Assurance Meeting for input and further direction. #3. the facility has an established 24 hour report system. Social Worker was re-educated on the use of the 24 hour report system and to ensure follow up of resident concerns. Nursing will be	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 250	Continued From page 8 warm while her roommate was often cold. R65 ' s roommate was R39 who was interviewed on 6/3/14 at 2:06 p.m.. R39 stated R65 liked to go to bed late and leave the light on. R39 stated that at 2:00 a.m. last night she had to ask R65 to shut off the light. During an interview on 6/4/14 at 1:00 p.m. licensed practical nurse (LPN)-A stated she was aware of the roommate issues. LPN-A stated that R65 would like to share the window with roommate R39. LPN-A thinks someone should tell the social worker (LSW) to get R65 a different room. Nursing notes dated 5/23/14 at 22:30 (10:30 p.m.) indicated R65 had been upset with her roommate that evening. R65 was in the room having a telephone conversation and had the over-bed light on, the roommate turned R65's lights off even though R65 was awake and on the telephone. The notes also indicated R65 was requesting to have dresser drawers assigned to her for her belongings since the roommate had moved items into R65's personal space. Nursing notes dated 5/26/14 at 2200 (10:00 p.m.) indicated R65 was dissatisfied with the room temperature and had asked if the window could be split somehow with the roommate. The note indicated these issues were referred to social services. LSW-A was interviewed on 6/4/14 at 8:50 a.m. and stated she was aware of the roommate issues concerning the light on at night, but had not put anything into effect. LSW-A stated she was not aware of issues related to temperature or age difference (R65 was much younger than	F 250	re-educated on June 19, 2014 to address room or roommate concerns in the 24 hour report to alert Social Services to any problems. #4. All residents will be assessed through the PHQ-09 quarterly, annually and with change of condition/significant changes to ensure psychological concerns are addressed. #5. Resident interviews will be completed on all residents quarterly, annually and with change of condition/significant change basis. The collection of the data will be reviewed and discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for monitoring: Lita Frederickson, LSW	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 250	Continued From page 9 R39.) On 6/5/14 at 8:50 a.m. LSW-A stated R65's roommate R39 had mentioned the lights being on during the night and LSW-A had suggested to nursing staff to turn the light off if R65 was sleeping. The director of nursing (DON) was interviewed on 6/5/14 at 10:23 a.m. and stated the nursing staff should report any roommate issues to anyone on the leadership team. DON stated she was unaware of R65 and R39 ' s concerns. DON felt compatibility should be reviewed for double occupancy rooms. DON stated R65 could not be given a private room, but the facility needed to look at roommate situation LSW-A was interviewed on 6/5/14 at 11:45 a.m. and stated R65 had adjustment issues related to age (younger than most residents in facility), health concerns, and nursing home placement. LSW-A also felt R65 had coping difficulties related to past health issues and family issues. Nor had LSW-A completed an assessment of R65 ' s psychosocial concerns to develop a plan to help R65 deal with the adjustment issues and self-coping issues. LSW stated she had not documented any conversations with R65 in regards to her coping and roommate issues.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 278	Continued From page 10 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify broken and carious teeth on the admission MDS (Minimum Data Set) for 1 of 3 residents (R6) reviewed for dental status and services. Findings include: Observation on 6/3/14, at 2:44 p.m., revealed R6 had broken, carious teeth (teeth affected with cavities or decay) on upper and lower gum lines. During observation on 6/4/14, at 11:35 a.m., licensed practical nurse (LPN)-A verified R6 had broken and carious teeth on upper and lower gum	F 278	The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F278	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 278	Continued From page 11 lines. R6 ' s admission record indicated she was admitted on 3/19/14 identified diagnosis of but not limited to congestive heart failure. R6's admission MDS dated 3/26/14, revealed no oral or dental problems had been identified during the seven day assessment period. However the facility oral/dental assessment dated 3/19/14, had identified R6 had own teeth, broken teeth and missing teeth. During interview on 6/4/14, at 11:47 a.m., registered nurse (RN)-A and RN-F, nurse consultant both verified R6's facility oral/dental assessment dated 3/19/14, had identified R6 had own teeth, broken teeth, missing teeth and R6's admission MDS dated 3/26/14 had no oral or dental problems identified. RN-A and RN-F both stated the assessment dated 3/19/14 had not flowed through to the admission MDS dated 3/26/14, and identified there was a system problem. During interview on 6/4/14, at 11:50 a.m., director of nursing had stated she would expect oral/dental problems on the facility assessment dated 3/19/14 to be carried over to the admission MDS dated 3/26/14. Document review of the facility Oral Assessment Guidelines undated, read, "Oral and dental health is a critical part of an individual's overall health and well being. Oral and dental problems may lead to infection, weight loss, pain or other disease complications. The Oral Assessment is completed upon admission and quarterly in conjunction with the MDS 3.0 and Nutritional	F 278	1. For R6 an oral assessment and a significant change MDS were completed on 6/10/14. They both identified oral/dental problems. 2. The MDS Coordinator/Assistant MDS Coordinator will ensure that all residents with oral/dental problems have them identified on the MDS. 3. Inservice training was held by the DNS (Director of Nursing Service) on June 18, 2014 for all licensed nurses to ensure that oral assessments are done correctly and that all dental problems are indentified on the MDS. 4. The DNS/Designee will audit residents' oral assessments and MDSs weekly until substantial compliance to ensure that all residents have dental problems properly identified. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for monitoring: DNS/Designee	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 278	Continued From page 12 Assessment."	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to consistently update falls interventions after falls assessment was completed for 1 of 2 residents (R35) who had history of falls. Findings Include: R35 had been admitted on 1/7/13 according to R35's order summary report dated 4/22/14 and	F 280	The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 280	Continued From page 13 also identified diagnoses of but not limited to senile dementia, unspecified psychosis, depressive disorder, and agoraphobia with panic disorder. R35' s significant change in status Minimum Data Set (MDS) dated 5/019/2014, indicated R35 had severely impaired cognition, had falls since admission or prior assessment and one with injury. R35's post fall investigation dated 3/24/14 had identified R35 had a fall on 3/24/14, at 4:00 p.m. A progress noted dated 3/25/14 read, "...Fall at 1600 [4:00 p.m.] hr [hour] on 3/24/14 reviewed by the IDT [interdisciplinary team]. No injuries were sustained from falling in her room. Activity aid (sic) was assisting her to sit in a chair when she became weak and was lowered to the floor. Resident had been walked to her room from the lobby. Interventions: To use w/c [wheelchair] for assisting resident longer distances." R35's post fall investigation dated 4/23/14; identified R35 had a fall on 4/23/14, at 10:43 a.m. Nurse progress note dated 4/25/14 read, "Fall on 4/23/14 at 1043 [10:43 a.m.] hr reviewed by the IDT. Resident self -transferred from the w/c in the South lobby. Interventions: high back w/c with anti-lock brakes, to have on gripper socks and no foot pedals, to be under direct observation when in w/c." R35's post fall investigation dated 4/30/14; identified R35 had a fall on 4/30/14, at 10:15 a.m. Nurse progress note dated 5/1/14 read, "IDT met along with PTA [physical therapy assistant] r/t [related to] recent fall in front lobby." R35 "continues to make unsafe moves and does become weak and unsteady. Staff needs to ensure that she has her self locking chair	F 280	foregoing statement, the facility states that with respect to: F280 1. The comprehensive care plans and nursing assistant care plan for R9 and R35 were reviewed and updated to include interventions relating to their fall histories. 2. Licensed nursing staff will update the comprehensive care plan and the nursing assistant care plan when a resident has had a fall assessment and new interventions have been identified. 3. Inservice training was held by the DNS on June 19, 2014 for all licensed nurses on the need to update the comprehensive care plans and the nursing assistant care plans when a resident has had a fall assessment and new interventions have been identified. 4. The DNS/Designee will audit the comprehensive care plans and the nursing assistant care plans 2 times per week 4 weeks and then weekly until substantial compliance to ensure that the fall interventions are consistently updated. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for monitoring:	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 280	Continued From page 14 whenever possible." R35 "will get up on her own and start to ambulate. Staff to continue hourly customer service rounds to interact with her r/t pain, positioning, personal needs, and placement of personal items." R35's comprehensive care plan with a review date 4/22/14 read R35 had multiple falls since her admission. She does have risk factors for further falls: Dementia, incontinence, HTN [hypertension], use of psychotropic and antihypertensive medications, unsteady gait, impaired balance, weakness. Interventions included: Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed in low position at night, personal items within reach. Review information on past falls and attempt to determine cause of falls, document findings and Alter or remove any potential causes if possible. Ensure that R35 is wearing appropriate footwear (shoes, bedroom slippers, non-skid socks) when ambulating or up in w/c. Anticipate and meet needs. Fall risk assessment quarterly and PRN [as needed]. Hourly Customer Service Rounds to interact with her and observe for pain, position, personal need, and placement of personal items in the environment. Assist to toilet every 3 hours and check on her every hour. Staff to assist with donning her gripper stockings (She may remove them). When she is in the recliner, do not put her feet up and put the chair in a reclined position. R35's care plan also read Ambulate: R35 does ambulate independently throughout the facility, however may become weak and require assist of one to two. A wheelchair may be required if she is unable to continue to walk." R35's care plan had not been revised to include	F 280	DNS/Designee	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 280	Continued From page 15 the following fall interventions after falls dated 3/24/14, 4/23/14 and 4/30/14: To "use w/c for assisting resident longer distances, to be under direct observation when in w/c, lipped mattress and staff needs to ensure that she has her self locking chair whenever possible." During an interview on 6/5/14 at 8:14 a.m., the director of nursing stated R35's abilities very greatly from day to day, there are days when it takes two people to transfer her and days when she is able to stand independently and walk on her own. The DON stated it is a day to day assessment of R35's abilities to see what level of care staff needed to provide. The DON verified the care plan had not been revised to reflect R35 was not to ambulate independently in the facility. The DON verified R35's care plan had not been revised to include the fall interventions to, use the wheelchair for assisting resident longer distances, to be under direct observation when in the wheelchair and the use of a lipped mattress and staff needs to ensure that she has her self locking chair whenever possible. The DON stated the fall interventions have not always been getting on the care plan and stated her expectation was the care plan would be updated to include new fall interventions after the IDT review of each fall. The DON also verified fall interventions were not included for R35 on the nursing assistant care plan.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 318	Continued From page 16 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (R9) received restorative nursing as recommended by therapy. Findings include: R9 was observed on 6/3/14 at 3:00 p.m. sitting in the wheelchair in the room. R9 was able to independently move the wheelchair. A red piece of sticky Dicem (non-slip material) was noted on the straight chair in the room. R9 stated he did not know why it was there since he had never fallen from a chair. R9 was admitted to the facility in August 2012 with a history of multiple falls according to R9 ' s comprehensive care plan dated 6/4/14. Fall risk data collection and assessment forms were reviewed for April 2014 through May 2014. The fall risk forms indicated falls were noted on 10 days with more than one fall on several of those days. The quarterly Minimum Data Set (MDS) dated 4/14/14 was reviewed. R9 had a BIMS (brief interview of mental status) score of 14/15 or no cognitive impairment also indicated R9 required extensive assistance with transfers, did not walk, experienced two or more falls in previous quarter, planned to return to the community, and had last had physical therapy June 2013.	F 318	The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F318 1. R9 was re-evaluated by OT on 06/13/14 and is currently receiving therapy 3x per week to address falls. 2. The licensed nursing staff will ensure that Restorative Carryover Programs developed and recommended by therapy are completed and documented by the nursing assistants and/or the Community Life staff (activity department). Restorative Carryover will focus on ROM and walking programs carried out by the nursing assistants and the Wellness Program exercises led by the Community Life staff. 3. Physical Therapy/DNS will inservice all nursing assistants and the Community Life staff on June 25 and 26, 2014 on the	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 318	Continued From page 17 On 5/13/13 therapy had provided Nursing/Restorative Carryover program that included seated and standing exercise and ambulation. Review of provided documentation noted restorative program was provided in July 2013 and in January 2014. Registered Nurse (RN)-A was interviewed on 6/5/14 at 11:50 a.m. and stated she was responsible for the restorative nursing program. She stated she was unable to find any additional documentation related to the provision of services. R9's care plan dated 6/4/14 was reviewed. The care plan identified a problem of multiple falls related to impaired gait and balance, poor safety awareness, cognitive impairment, non-compliance with interventions in place for his safety. The interventions included physical therapy and occupational therapy evaluations and treatments. The physical therapist discharge summary dated 5/29/14 indicated R9 had attended physical therapy 5/7/14 through 5/29/14. Physical therapy assessed and treated R9 for ambulation, strength, and transfer between surfaces. The notes indicated a long-standing gait abnormality and poor balance with frequent falls. Therapy provided Nursing/Restorative Carry over Program dated 5/29/14 that included seated exercises and stretches to be completed 3 to 6 times a week. The director of nursing (DON) was interviewed on 6/5/14 at 10:36 a.m. DON stated restorative nursing was the responsibility of RN-A and the facility had two restorative nursing assistants trained and assigned to do range of motion and stretching exercises. The restorative nursing	F 318	Restorative Carryover Programs and the importance of following the recommendations of the therapy services. 4. The DNS/Designee will audit the Carryover Program documentation weekly until substantial compliance to ensure that residents are receiving restorative activities as recommended by therapy. Responsible for monitoring: DNS/Designee	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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
F 318	Continued From page 18 assistants were to document completion and that RN-A was to provide the oversight of the program. RN-A was interviewed on 6/5/14 at 12:00 p.m. RN-A stated the facility no longer had a restorative nursing program since many residents attended an activity exercise program. RN-A stated R9 did not attend the activity exercise program.	F 318		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 425	The preparation of the following	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 425	Continued From page 19 facility failed to document destruction (releasing and/or destroying discontinued or expired medications) of medications for residents. This had the potential to affect 48 of 48 residents residing in the facility. Findings include: During interview on 6/5/14, at 11:07 a.m., director of nursing had stated I do not think we have a specific form for resident individual medication destruction. Director of nursing had stated (when asked to show documentation of destruction of medications for residents other than medications sent back to the pharmacy or of narcotics) the facility does not have record in the residents ' chart of any individual medication destruction. Director of nursing had stated the only records we have of medications are the ones sent back to the pharmacy and destruction of narcotics. During interview on 11/5/14, at 11:44 a.m., facility consultant pharmacist had stated would expect the facility to document destroyed medications, write down residents name and what they destroyed. Document review of the facility policy Disposal/Destruction of Expired or Discontinued Medications revision date 1/1/13, read, "Procedure: 5. Facility should destroy non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with Facility policy or Applicable Law. 6. Facility should enter the following information on the drug destruction form when medications are destroyed: 6.1 Resident's name; 6.2 Name and strength of medication; 6.3 Prescription number; 6.4 Amount of medication	F 425	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F425 1. In accordance with State and Federal laws, the facility will enter the following information on a drug disposition from when medications other than narcotics are destroyed: A. Resident's name B. Name and strength of medication destroyed C. Prescription number D. Amount of medication (dosage units) destroyed E. Date of destruction F. Signature of person destroying the drugs and the signature of a witness and G. Method of destruction. 2. The Disposal/Destruction of Expired or Discontinued Medications Policy will be followed for the destruction of any medications for the residents other than narcotics. The drug disposition form provided by the pharmacy will be used for destruction. 3. Inservice training was presented on June 19, 2014 by the DNS for all licensed nurses on the proper documentation of drug destruction other than narcotics.	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 425	Continued From page 20 (dosage units) destroyed; 6.5 Date of destruction; 6.6 Signature of witnesses; and, 6.7 Method of disposition, including donation as permitted by Applicable Law."	F 425	4. The DNS/Designee will audit the drug disposition forms 2x per week for 4 weeks and then weekly until substantial compliance to ensure that there is proper documentation of drug destruction. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for monitoring: DNS/Designee	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 431	Continued From page 21 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the insulin vial prescription label was correct for 1 of 2 residents (R45) reviewed for insulin administration. Findings include: R45 was observed during medication administration on 6/4/14 at 7:50 a.m. The insulin vial had a pharmacy printed label indicating R45 was to receive 40 units of Levemir insulin daily. Registered nurse (RN)-D was observed to draw 55 units of insulin into the syringe. RN-D stated the order had been changed. RN-D verified the vial had no indication of order changes. R45's physician orders were reviewed. On 5/5/14 the physician discontinued Lantus insulin and start Levemir 40 units of insulin daily as soon as the Lantus insulin vial was empty. On 5/28/14 the physician increased the Levemir insulin to 50 units daily and on 6/2/14 increased the Levemir insulin to 55 units daily. On 6/4/14 at 7:50 a.m. RN-B stated the insulin	F 431	The preparation of the following correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without the foregoing statement, the facility states that with respect to: F431 1. R45 has a label on his insulin vial which states, "medication changed refer to med sheet." When a new bottle is ordered from the pharmacy a licensed nurse will ensure that the correct label according to the physicians orders is also ordered and on the vial when it arrives. 2. The licensed nursing staff will ensure that when an insulin order is changed a	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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
F 431	Continued From page 22 vial should have a sticker on the vial and placed it on the vial at that time. The sticker indicated an order change and to check physician orders. On 6/4/14 at 9:50 a.m. the director of nursing indicated either a new pharmacy label or sticker indicating change should have been placed on the insulin vial to indicate physician order changes. The facility policy dated 12/1/07 entitled Reordering, Changing, and Discontinuing Orders was reviewed. The policy/procedure indicated that if the physician changed an order dosage and the resident still had sufficient quantity on hand, the facility was to attach a change in directions sticker to the existing quantity of medication until the pharmacy permanently affixed the new label to the medication package or container.	F 431	"medication changed refer to med sheet" label is attached to the vial until a new vial is ordered with the correct label. 3. Inservice training was presented by the DNS for licensed nurses on June 19, 2014 to re-educate on the proper labeling of insulin vials with a dosage change. 4. The DNS/Designee will audit insulin labels weekly until substantial compliance to ensure that the vial has the correct order or a "medication changed refer to med sheet" label. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions, and ongoing audits. Responsible for monitoring: DNS/Designee	

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 _____	**06/04/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Green Lea Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 06/24/2014

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.

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 _____	**06/04/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By email to Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Green Lea Manor is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1969, addition was constructed and was determined to be of Type II(222) construction. In 1989, another two additions were constructed and was determined to be of Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building Type II (111) .

The building is fully sprinkled and has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 51 beds and had a census of 48 at the time of the survey.

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 _____	**06/04/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 48 residents. Findings include: On facility tour between 8:30 AM and 10:45 AM on 06/04/2014, the review of the fire drill reports for June 2013 to May 2014 and the 2013 - 3rd quarter night shift drill was missed. This deficient practice was confirmed by the Facility Maintenance Director (SD) at the time of discovery.	K 050	A Fire Drill will be held on 6/19/14 on the PM shift. Fire Drills will be conducted at various times on each shift at least quarterly. This will be documented by the Maintenance Supervisor. An audit will be completed quarterly by the ED(Administrator)/Designee.	7/1/14

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 _____	**06/04/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
June 12, 2014

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rr 2 Box 49
Mabel, Minnesota 55954

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5536023

Dear Ms. Vettleson:

The above facility was surveyed on June 2, 2014 through June 5, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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) COMPLETE DATE
2 000	Continued From page 1 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. On 6/2, 6/3, 6/4 and 6/5/14 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet psychosocial needs related to roommate concerns, adjustment to health changes and nursing home placement, coping skills for 1 of 1 resident (R65). Findings include: R65 was admitted to the facility 4/30/14 according to the admission sheet. The care plan dated 6/2/14 listed diagnoses that included: cognitive impairment, stroke with right sided hemiplegia, peripheral vascular disease, heart disease, anxiety, and depression.	2 435	Corrected	6/19/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 435	Continued From page 3 On 6/13/14 at 2:15 p.m. R65 was observed sitting in a wheelchair and was propelling the wheelchair with her left foot. R65 shared her room with another resident. R65 bed was located next to the bedroom door. On 6/3/14 R65 was observed lying in bed with over-bed light turned on. R65 had a fan blowing directly at her-less than 2 feet from her body. The privacy curtain was pulled between the two residents which fully blocked R65's view through the window. The roommate was not in the room at this time. R65 was interviewed on 6/3/14 at 2:13 p.m. R65 stated she was in the nursing home because she had a stroke. R65 stated she and her roommate did not always get along. R65 liked to stay up late and her roommate liked to go to bed early. R65 liked to have lights on when awake, but the roommate liked to have it dark when she would sleep. R65 stated it was too hot in her room so had a fan in her room. R65 stated she was warm while her roommate was often cold. R65 ' s roommate was R39 who was interviewed on 6/3/14 at 2:06 p.m.. R39 stated R65 liked to go to bed late and leave the light on. R39 stated that at 2:00 a.m. last night she had to ask R65 to shut off the light. During an interview on 6/4/14 at 1:00 p.m. licensed practical nurse (LPN)-A stated she was aware of the roommate issues. LPN-A stated that R65 would like to share the window with roommate R39. LPN-A thinks someone should tell the social worker (LSW) to get R65 a different room. Nursing notes dated 5/23/14 at 22:30 (10:30 p.m.) indicated R65 had been upset with her roommate that evening. R65 was in the room	2 435		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 435	Continued From page 4	2 435		

having a telephone conversation and had the over-bed light on, the roommate turned R65's lights off even though R65 was awake and on the telephone. The notes also indicated R65 was requesting to have dresser drawers assigned to her for her belongings since the roommate had moved items into R65's personal space. Nursing notes dated 5/26/14 at 2200 (10:00 p.m.) indicated R65 was dissatisfied with the room temperature and had asked if the window could be split somehow with the roommate. The note indicated these issues were referred to social services.

LSW-A was interviewed on 6/4/14 at 8:50 a.m. and stated she was aware of the roommate issues concerning the light on at night, but had not put anything into effect. LSW-A stated she was not aware of issues related to temperature or age difference (R65 was much younger than R39.) On 6/5/14 at 8:50 a.m. LSW-A stated R65's roommate R39 had mentioned the lights being on during the night and LSW-A had suggested to nursing staff to turn the light off if R65 was sleeping.

The director of nursing (DON) was interviewed on 6/5/14 at 10:23 a.m. and stated the nursing staff should report any roommate issues to anyone on the leadership team. DON stated she was unaware of R65 and R39 ' s concerns. DON felt compatibility should be reviewed for double occupancy rooms. DON stated R65 could not be given a private room, but the facility needed to look at roommate situation

LSW-A was interviewed on 6/5/14 at 11:45 a.m. and stated R65 had adjustment issues related to age (younger than most residents in facility), health concerns, and nursing home placement.

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 435	Continued From page 5 LSW-A also felt R65 had coping difficulties related to past health issues and family issues. Nor had LSW-A completed an assessment of R65 ' s psychosocial concerns to develop a plan to help R65 deal with the adjustment issues and self-coping issues. LSW stated she had not documented any conversations with R65 in regards to her coping and roommate issues. SUGGESTED METHOD OF CORRECTION: The administrator could provide training for the social service department on the need to follow the policy and procedure in cases of room mate conflict. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by:	2 570		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 570	Continued From page 6 Based on observation, record review and interview, the facility failed to consistently update falls interventions after falls assessment was completed for 1 of 2 residents (R35) who had history of falls. Findings Include: R35 had been admitted on 1/7/13 according to R35's order summary report dated 4/22/14 and also identified diagnoses of but not limited to senile dementia, unspecified psychosis, depressive disorder, and agoraphobia with panic disorder. R35' s significant change in status Minimum Data Set (MDS) dated 5/019/2014, indicated R35 had severely impaired cognition, had falls since admission or prior assessment and one with injury. R35's post fall investigation dated 3/24/14 had identified R35 had a fall on 3/24/14, at 4:00 p.m. A progress noted dated 3/25/14 read, "...Fall at 1600 [4:00 p.m.] hr [hour] on 3/24/14 reviewed by the IDT [interdisciplinary team]. No injuries were sustained from falling in her room. Activity aid (sic) was assisting her to sit in a chair when she became weak and was lowered to the floor. Resident had been walked to her room from the lobby. Interventions: To use w/c [wheelchair] for assisting resident longer distances." R35's post fall investigation dated 4/23/14; identified R35 had a fall on 4/23/14, at 10:43 a.m. Nurse progress note dated 4/25/14 read, "Fall on 4/23/14 at 1043 [10:43 a.m.] hr reviewed by the IDT. Resident self -transferred from the w/c in the South lobby. Interventions: high back w/c with anti-lock brakes, to have on gripper socks and no foot pedals, to be under direct observation when in w/c."	2 570	Corrected	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 570	Continued From page 7 R35's post fall investigation dated 4/30/14; identified R35 had a fall on 4/30/14, at 10:15 a.m. Nurse progress note dated 5/1/14 read, "IDT met along with PTA [physical therapy assistant] r/t [related to] recent fall in front lobby." R35 "continues to make unsafe moves and does become weak and unsteady. Staff needs to ensure that she has her self locking chair whenever possible." R35 "will get up on her own and start to ambulate. Staff to continue hourly customer service rounds to interact with her r/t pain, positioning, personal needs, and placement of personal items." R35's comprehensive care plan with a review date 4/22/14 read R35 had multiple falls since her admission. She does have risk factors for further falls: Dementia, incontinence, HTN [hypertension], use of psychotropic and antihypertensive medications, unsteady gait, impaired balance, weakness. Interventions included: Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed in low position at night, personal items within reach. Review information on past falls and attempt to determine cause of falls, document findings and Alter or remove any potential causes if possible. Ensure that R35 is wearing appropriate footwear (shoes, bedroom slippers, non-skid socks) when ambulating or up in w/c. Anticipate and meet needs. Fall risk assessment quarterly and PRN [as needed]. Hourly Customer Service Rounds to interact with her and observe for pain, position, personal need, and placement of personal items in the environment. Assist to toilet every 3 hours and check on her every hour. Staff to assist with donning her gripper stockings (She may remove	2 570		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 570	Continued From page 8 them). When she is in the recliner, do not put her feet up and put the chair in a reclined position. R35's care plan also read Ambulate: R35 does ambulate independently throughout the facility, however may become weak and require assist of one to two. A wheelchair may be required if she is unable to continue to walk." R35's care plan had not been revised to include the following fall interventions after falls dated 3/24/14, 4/23/14 and 4/30/14: To "use w/c for assisting resident longer distances, to be under direct observation when in w/c, lipped mattress and staff needs to ensure that she has her self locking chair whenever possible." During an interview on 6/5/14 at 8:14 a.m., the director of nursing stated R35's abilities very greatly from day to day, there are days when it takes two people to transfer her and days when she is able to stand independently and walk on her own. The DON stated it is a day to day assessment of R35's abilities to see what level of care staff needed to provide. The DON verified the care plan had not been revised to reflect R35 was not to ambulate independently in the facility. The DON verified R35's care plan had not been revised to include the fall interventions to, use the wheelchair for assisting resident longer distances, to be under direct observation when in the wheelchair and the use of a lipped mattress and staff needs to ensure that she has her self locking chair whenever possible. The DON stated the fall interventions have not always been getting on the care plan and stated her expectation was the care plan would be updated to include new fall interventions after the IDT review of each fall. The DON also verified fall interventions were not included for R35 on the nursing assistant care plan. SUGGESTED METHOD OF CORRECTION:	2 570		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 570	Continued From page 9 Staff responsible for updating resident care plans need to be educated on the need to update information when a resident has a change in condition and has new interventions in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (R9) received restorative nursing as recommended by therapy. Findings include: R9 was observed on 6/3/14 at 3:00 p.m. sitting in the wheelchair in the room. R9 was able to independently move the wheelchair. A red piece of sticky Dicem (non-slip material) was noted on	2 895	Corrected	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 895	Continued From page 10 the straight chair in the room. R9 stated he did not know why it was there since he had never fallen from a chair. R9 was admitted to the facility in August 2012 with a history of multiple falls according to R9 ' s comprehensive care plan dated 6/4/14. Fall risk data collection and assessment forms were reviewed for April 2014 through May 2014. The fall risk forms indicated falls were noted on 10 days with more than one fall on several of those days. The quarterly Minimum Data Set (MDS) dated 4/14/14 was reviewed. R9 had a BIMS (brief interview of mental status) score of 14/15 or no cognitive impairment also indicated R9 required extensive assistance with transfers, did not walk, experienced two or more falls in previous quarter, planned to return to the community, and had last had physical therapy June 2013. On 5/13/13 therapy had provided Nursing/Restorative Carryover program that included seated and standing exercise and ambulation. Review of provided documentation noted restorative program was provided in July 2013 and in January 2014. Registered Nurse (RN)-A was interviewed on 6/5/14 at 11:50 a.m. and stated she was responsible for the restorative nursing program. She stated she was unable to find any additional documentation related to the provision of services. R9's care plan dated 6/4/14 was reviewed. The care plan identified a problem of multiple falls related to impaired gait and balance, poor safety awareness, cognitive impairment, non-compliance with interventions in place for his	2 895		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 895	Continued From page 11 safety. The interventions included physical therapy and occupational therapy evaluations and treatments. The physical therapist discharge summary dated 5/29/14 indicated R9 had attended physical therapy 5/7/14 through 5/29/14. Physical therapy assessed and treated R9 for ambulation, strength, and transfer between surfaces. The notes indicated a long-standing gait abnormality and poor balance with frequent falls. Therapy provided Nursing/Restorative Carry over Program dated 5/29/14 that included seated exercises and stretches to be completed 3 to 6 times a week. The director of nursing (DON) was interviewed on 6/5/14 at 10:36 a.m. DON stated restorative nursing was the responsibility of RN-A and the facility had two restorative nursing assistants trained and assigned to do range of motion and stretching exercises. The restorative nursing assistants were to document completion and that RN-A was to provide the oversight of the program. RN-A was interviewed on 6/5/14 at 12:00 p.m. RN-A stated the facility no longer had a restorative nursing program since many residents attended an activity exercise program. RN-A stated R9 did not attend the activity exercise program. SUGGESTED METHOD OF CORRECTION: Director of nursing could inservice all staff responsible for maintaining and delivering rehabilitative services on the need to follow the recommendation of physical therapy. TIME PERIOD FOR CORRECTION: Twenty-one	2 895		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
2 895	Continued From page 12 (21) days.	2 895		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet psychosocial needs related to roommate concerns, adjustment to health changes and nursing home placement, coping skills for 1 of 1 resident (R65). Findings include: R65 was admitted to the facility 4/30/14 according to the admission sheet. The care plan dated 6/2/14 listed diagnoses that included: cognitive impairment, stroke with right sided hemiplegia, peripheral vascular disease, heart disease, anxiety, and depression. On 6/13/14 at 2:15 p.m. R65 was observed sitting in a wheelchair and was propelling the wheelchair with her left foot. R65 shared her room with another resident. R65 bed was located next to the bedroom door. On 6/3/14 R65 was observed lying in bed with over-bed light turned on. R65 had a fan blowing directly at her-less than 2 feet from her body. The privacy curtain was pulled between the two residents which fully blocked	21495	Corrected	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21495	Continued From page 13 R65's view through the window. The roommate was not in the room at this time. R65 was interviewed on 6/3/14 at 2:13 p.m. R65 stated she was in the nursing home because she had a stroke. R65 stated she and her roommate did not always get along. R65 liked to stay up late and her roommate liked to go to bed early. R65 liked to have lights on when awake, but the roommate liked to have it dark when she would sleep. R65 stated it was too hot in her room so had a fan in her room. R65 stated she was warm while her roommate was often cold. R65 ' s roommate was R39 who was interviewed on 6/3/14 at 2:06 p.m.. R39 stated R65 liked to go to bed late and leave the light on. R39 stated that at 2:00 a.m. last night she had to ask R65 to shut off the light. During an interview on 6/4/14 at 1:00 p.m. licensed practical nurse (LPN)-A stated she was aware of the roommate issues. LPN-A stated that R65 would like to share the window with roommate R39. LPN-A thinks someone should tell the social worker (LSW) to get R65 a different room. Nursing notes dated 5/23/14 at 22:30 (10:30 p.m.) indicated R65 had been upset with her roommate that evening. R65 was in the room having a telephone conversation and had the over-bed light on, the roommate turned R65's lights off even though R65 was awake and on the telephone. The notes also indicated R65 was requesting to have dresser drawers assigned to her for her belongings since the roommate had moved items into R65's personal space. Nursing notes dated 5/26/14 at 2200 (10:00 p.m.) indicated R65 was dissatisfied with the room	21495		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21495	Continued From page 14	21495		

temperature and had asked if the window could be split somehow with the roommate. The note indicated these issues were referred to social services.

LSW-A was interviewed on 6/4/14 at 8:50 a.m. and stated she was aware of the roommate issues concerning the light on at night, but had not put anything into effect. LSW-A stated she was not aware of issues related to temperature or age difference (R65 was much younger than R39.) On 6/5/14 at 8:50 a.m. LSW-A stated R65's roommate R39 had mentioned the lights being on during the night and LSW-A had suggested to nursing staff to turn the light off if R65 was sleeping.

The director of nursing (DON) was interviewed on 6/5/14 at 10:23 a.m. and stated the nursing staff should report any roommate issues to anyone on the leadership team. DON stated she was unaware of R65 and R39 ' s concerns. DON felt compatibility should be reviewed for double occupancy rooms. DON stated R65 could not be given a private room, but the facility needed to look at roommate situation

LSW-A was interviewed on 6/5/14 at 11:45 a.m. and stated R65 had adjustment issues related to age (younger than most residents in facility), health concerns, and nursing home placement. LSW-A also felt R65 had coping difficulties related to past health issues and family issues. Nor had LSW-A completed an assessment of R65 ' s psychosocial concerns to develop a plan to help R65 deal with the adjustment issues and self-coping issues. LSW stated she had not documented any conversations with R65 in regards to her coping and roommate issues.

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21495	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The facility needs to provide social services to meet the needs of residents. Education of nurses, social service employees needs to be educated on their roll to meet these phsycho social needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the insulin vial prescription label was correct for 1 of 2 residents (R45) reviewed for insulin administration. Findings include: R45 was observed during medication administration on 6/4/14 at 7:50 a.m. The insulin vial had a pharmacy printed label indicating R45 was to receive 40 units of Levemir insulin daily. Registered nurse (RN)-D was observed to draw 55 units of insulin into the syringe. RN-D stated the order had been changed. RN-D verified the vial had no indication of order changes. R45's physician orders were reviewed. On 5/5/14 the physician discontinued Lantus insulin and start Levemir 40 units of insulin daily as soon as the Lantus insulin vial was empty. On 5/28/14 the physician increased the Levemir insulin to 50 units daily and on 6/2/14 increased the Levemir	21620	Corrected	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21620	Continued From page 16 insulin to 55 units daily. On 6/4/14 at 7:50 a.m. RN-B stated the insulin vial should have a sticker on the vial and placed it on the vial at that time. The sticker indicated an order change and to check physician orders. On 6/4/14 at 9:50 a.m. the director of nursing indicated either a new pharmacy label or sticker indicating change should have been placed on the insulin vial to indicate physician order changes. The facility policy dated 12/1/07 entitled Reordering, Changing, and Discontinuing Orders was reviewed. The policy/procedure indicated that if the physician changed an order dosage and the resident still had sufficient quantity on hand, the facility was to attach a change in directions sticker to the existing quantity of medication until the pharmacy permanently affixed the new label to the medication package or container. SUGGESTED METHOD OF CORRECTION: The pharmacist could inservice all staff responsible for medication program the need to follow state requirements to have an accurate label when dispensing medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were	21630		7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21630	Continued From page 17 prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document destruction (releasing and/or destroying discontinued or expired medications) of medications for residents. This had the potential to affect 48 of 48 residents residing in the facility. Findings include: During interview on 6/5/14, at 11:07 a.m., director of nursing had stated I do not think we have a specific form for resident individual medication destruction. Director of nursing had stated (when asked to show documentation of destruction of medications for residents other than medications sent back to the pharmacy or of narcotics) the	21630	Corrected	

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21630	Continued From page 18 facility does not have record in the residents ' chart of any individual medication destruction. Director of nursing had stated the only records we have of medications are the ones sent back to the pharmacy and destruction of narcotics. During interview on 11/5/14, at 11:44 a.m., facility consultant pharmacist had stated would expect the facility to document destroyed medications, write down residents name and what they destroyed. Document review of the facility policy Disposal/Destruction of Expired or Discontinued Medications revision date 1/1/13, read, "Procedure: 5. Facility should destroy non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with Facility policy or Applicable Law. 6. Facility should enter the following information on the drug destruction form when medications are destroyed: 6.1 Resident's name; 6.2 Name and strength of medication; 6.3 Prescription number; 6.4 Amount of medication (dosage units) destroyed; 6.5 Date of destruction; 6.6 Signature of witnesses; and, 6.7 Method of disposition, including donation as permitted by Applicable Law." SUGGESTED METHOD OF CORRECTION: Pharmacist could inservice all staff responsible for medication program in the facility the need to document the destruction of medications when a resident leaves the facility or dies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21800	Continued From page 19	21800		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to review resident rights during residents stay at the facility. This also includes	21800	Corrected	7/1/14

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21800	Continued From page 20	21800		

the right to have lost items investigated for resident (R20) who lost personal items. This had the potential to affect 48 of 48 residents residing in the facility.

Findings include:

During interview on 6/4/14, at 11:50 a.m., R39 had stated, " No " when asked by surveyor does the staff talk about and review the rights of residents in the facility.

Document review of the facility resident council minutes dated 3/5/14, 4/2/14 and 5/1/14, revealed residents rights had not been reviewed.

During interview on 6/4/14, at 5:00 p.m., activity director had stated I have not reviewed rights at resident council meetings. Activity director had stated social worker would do that.

During interview on 6/4/14, at 12:17 p.m., social worker had stated I have not been reviewing resident rights; it should be done at resident council. Social worker had stated if activity director had not been doing it then it has not been getting done.

During interview on 6/4/14, at 12:55 p.m., activity director stated I have not been doing on my end in regards to reviewing resident rights and had looked back through resident council meeting minutes dated 7/13 through 5/14, at the time and verified resident rights had not been reviewed.

Document review of the facility Tealwood Care Centers Corporate Compliance Manual Residents' Rights & Quality of Life policy date issued 9/1/04, read, "Elements A resident has the right: To be fully informed of his or her rights and

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	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) COMPLETE DATE
21800	Continued From page 21 all the rules and regulations governing resident conduct and responsibilities during the stay in the facility." Missing personal belongings: R20 had been admitted on 8/18/09 according to the face sheet. During family interview on 6/3/14, at 5:59 p.m., family member (F)-D had stated R20 had a missing magnifying glass and two rosaries. F-D had stated administrator had been told and had not responded back regarding missing items and then stated they don ' t tell anyone about missing things anymore and had stated rosaries are important to R20. During interview on 6/4/14, at 1:15 p.m.., social worker had stated she was aware of the missing magnifying glass and rosaries, F-D had reported it to her and they had moved R20's waste basket away from tray table so items on tray table would not be able to fall into garbage. At 1:45 p.m., social worker stated she did not know the date of when the magnifying glass and rosaries had been reported missing, no grievance report had been filled out, no documentation had been done regarding missing magnifying glass and rosaries. At 2:30 p.m., social worker verified they had not followed system policy in regards to lost or missing property. Document review of the facility GREEN LEA MANOR HEALTH CARE CENTER policy Lost or Missing Property dated 5/28/09, read, "If item is not found 1. Complete a Lost or Missing Property Form & give to Social Services 5. If the item is not recovered within 30 days the resident &/or responsible party for the resident will be notified by Social Services. This will be documented in the resident's Social Services progress notes."	21800		

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 _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	**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) COMPLETE DATE
21800	Continued From page 22 SUGGESTED METHOD OF CORRECTION: The director of nursing or social worker could inservice all staff responsible to educate residents on there patient rights. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		