

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered March 16, 2021

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

RE: CCN: 245536 Cycle Start Date: February 3, 2021

Dear Administrator:

On March 11, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Mi This

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 18, 2021

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

RE: CCN: 245536 Cycle Start Date: February 3, 2021

Dear Administrator:

On February 3, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 3, 2021 (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).

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In addition, if substantial compliance with the regulations is not verified by August 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Feel free to contact me if you have questions.

Sincerely,

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

DEPAR	IMENT OF HEALTH	I AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY IPLETED
		245536	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2021
GREEN I	EA SENIOR LIVING				15 NORTH LYNDALE, RR 2 BOX 49		
				IV	1ABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 0	000			
	completed at your f investigation. Your	/21 an abbreviated survey was facility to conduct a complaint facility was found NOT to be in CFR Part 483, Requirements e Facilities.					
		plaint was found to be H5536006C, with a deficiency					
	UNSUBSTANTIAT	plaint was found to be ED: H5536005C, with cis cited at F609 and F610.					
		f correction (POC) will serve f compliance upon the ptance.					
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
F 609 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Reporting of Allege		F 6	609			2/27/21
		onse to allegations of abuse, n, or mistreatment, the facility					
	§483.12(c)(1) Ensu	re that all alleged violations					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						02/26/2021

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.

PRINTED: 03/08/2021

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
		IDENTIFICATION NUMBER.	A. BUILDIN	NG		C	
		245536	B. WING			03/2021	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEN I	EA SENIOR LIVING			115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954	BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 609	Continued From pa	-	F 60	09			
	mistreatment, inclu source and misapp are reported immed hours after the alled that cause the alled serious bodily injury the events that cau abuse and do not re the administrator of officials (including t and adult protective provides for jurisdic	glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency e services where state law ction in long-term care ance with State law through ures.					
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct This REQUIREMEN by: Based on interview facility failed to ens	e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced v and document review, the ure the allegation of abuse		F 609 PLAN OF CORRECTION			
	within 2 hours of th	ministration and state agency e allegation of injury of r 1 of 1 (R2) resident reviewed		Green Lea Senior Living denies it any federal or state regulations. Accordingly, this plan of correctio not constitute an admission or ag by the provider to the accuracy of facts alleged or conclusions set for the statement of deficiencies. The	n does reement the orth in		
	noted a large bruis	ated 12/1/2020 at 9:01 p.m. e noted on right bicep, n x 6.5 cm and noted skin was		corrections is prepared and/or ex solely because it is required by th provisions of federal and state law Completion dates are provided fo procedural processing purposes a	ecuted e v. r		

Facility ID: 00124

If continuation sheet Page 2 of 27

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DATI	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
		245536	B. WING			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	5,2021
GREEN I	LEA SENIOR LIVING			115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 609	Vulnerable adult re occurred on 12/2/2 unexplained injury of bruise to right bicep on 12/2/20 at 1:53p Minnesota Departm Description of incid observed having a right bicep and 2cm the assigned nurse that the cause of the alleged perpetrator R2 admission recon- osteoarthritis, atrial failure, hypertensive disease with heart chronic gout, musc infection. R2 admission Minin assessment dated cognitive impairme assist with activities steady, history of fa R2 care plan includo self-transferring to requires 1 assist with as altered cardiov	port indicated incident 0 at 00:00 of physical abuse of with description of injury as b. Vulnerable report indicated b.m. was submitted to nent of Health (MDH). ent included resident was bruise 10cm x 6.5cm to outer n x 2 cm to inner right bicep by during routine skin check and the bruise is unknown. No was identified. rd included diagnoses of fibrillation, biventricular heart e heart and chronic kidney failure, type 2 diabetes, le weakness, and urinary tract mum Data Set (MDS) 11/22/20, identified severe nt no behaviors, extensive s of daily living, walker, not alls, pain. led R2 is often seen commode or bathroom, ith walker and gait belt; R2 ascular status related to atrial	F 60	 correlation with the most recently completed or accomplished correlation and do not correspond chronologically to the date the fact maintains it is in compliance with requirements of participation, or the corrective action was necessary. 1. In continuing compliance with F 609, Reporting of Alleged Viola CFR(s): 483.12(c)(1)(4) Green Lee Living corrected the deficiency by educating the Executive Director Director of Nursing on the process required notification to state ager 2/8/21 by the Accura Nurse Spece 2. To correct the deficiency and the problem does not recur all state adult policy by the Director of Nursing Spece audit all incidents that require state notification for timeliness upon our for 4 weeks and then monthly for months to ensure substantial contists is met. 3. As part of Green Lea Senior Licommitment to quality assurance 	ective sility the hat tions ea Senior and the s for icies on ialist. to ensure able sing cialist will te ccurrence 2 npliance vings , the	
	bruising/bleeding a practitioner of abno vulnerable adult rel abilities, impaired o communication skil or complaints imme skin integrity related	t failure and to observe for nd to notify medical ormalities; R2 is considered a ated to impaired physical cognitive status and Ils and to report any concerns ediately; R2 has impairment to d to impaired mobility, and incontinence and to		DNS and/or designee will report i concerns through the community Process.		

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		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY PLETED
		245536	B. WING	. <u> </u>			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 609	Continued From par observe, document It is noted that R2 of fragile skin and eas During an interview licensed practical n was assisting reside bruise on the upper assessed and mear stated R2 had beha black males taking not been caring for hurting her even if t LPN-A stated R2 di staff to care for her think the bruise occ stated she is aware and the timeframe a abuse and reporting error on her part if s DON and physician During an interview LPN-C stated any of skin should be repor nursing and physici LPN-C stated if a b resident how it hap unable to say then reported immediate	inge 3 c, and report any skin injuries. laughter reported R2 has thin sily gets skin tears and bruises. Ton 2/2/21 at 1:35 p.m., urse (LPN)-A stated the aide ent to bed and reported a right arm. LPN-A stated she sured the bruise. LPN-A aviors of complaining about care of her even if they had her or say the staff was they were not touching her. Id not prefer the black male . LPN-A stated she did not curred due to abuse. LPN-A e of vulnerable adult reporting and has been educated on g. LPN-A stated it would be an she did not report it to the at the time.		609	DEFICIENCY)	RIATE	DATE
	weekends if not at t body audits are dor documented. During an interview aide (NA)-A stated right upper arm and	called after hours and on facility. LPN-C stated weekly ne on all residents and on 2/2/21 at 2:41p.m., nurse she noticed the bruise on R2 d reported to nurse right away. a large solid bruise. NA-A					

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		AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245536	B. WING				C 03/2021
NAME OF PROVIDER OR	SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN LEA SENIOF	RLIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
PREFIX (EACH [DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
transferred During an director of of the bruis the investig have called before. DO no matter adult report occurred a DON confil reported la hours. Facility Vu the residen mistreatme property al unknown s explained report any The proce employed policy defin included th observed b injury could the injury of the alleged observed, make an in securing th review of t	stated sh d but cou interview nursing se the mi gation. D d her at t DN stated what time t was file and was u rmed the ate and s Inerable nt is free ent, misa nd exploi source su immedia maltreat dure incl by facility nition of i ne source oy any pe d not be s suspici or the loc procedure d abuse of a manda nital report	age 4 he was grabbed when being ld not state who it was. (DON) stated she was notified orning of 12/2/20 and began ON stated the nurse should ime of the finding the night d the procedure is to notify her e. DON stated the vulnerable ed because the bruise unknown for sure of the origin. e vulnerable adult report was hould have been done within 2 Adult Policy included to ensure from abuse, neglect, appropriation of resident tation and includes injuries of ustained that is not reasonably tely. It indicated the facility will ment of a vulnerable adult. uded mandated reporters y shall report immediately. The njury of unknown source e of the injury was not erson or the source of the explained by the resident and ous because of the intent of ation of the injury. Internal e included that during the shift or unexplained injury is first ated reporter will immediately ort to their supervisor after ints safety and following the ion, the supervisor will to the administrator and It included upon report to a	F	609			

Facility ID: 00124

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/08/2021 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY PLETED
		245536	B. WING			C 03/2021
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN LE	A SENIOR LIVING			115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610 SS=D SS=D SS=I SS=D SS=I SS=D SS=I SS=I	n question will be in placed under direct non-resident related non-resident related non-resident related non-resident related non-resident related non-resident related non-resident neatmini shall determine if th he criteria for repor eported immediate after forming the su supervisor, director will immediately inst of the reported alleg nclude interviews o vitness interviews, o esident health issu- nedication review. nvestigate/Prevent/ CFR(s): 483.12(c)(2) 483.12(c) In respon- neglect, exploitation nust: 483.12(c)(2) Have violations are thorous 483.12(c)(3) Preven- neglect, exploitation nvestigation is in pr 483.12(c)(4) Repon- nvestigations to the designated represen- accordance with Sta Survey Agency, with ncident, and if the a	spected abuse, the employee nterviewed, reassigned duties, supervision, assigned to a tasks or suspended pending tection of the resident. It strator or director of nursing e incident/allegation meets table incident which will be ly but no later than 2 hours spicion. It indicated the of nursing, or administrator titute an internal investigation gation or incident which may f staff, resident interviews, environmental review, es, behavior review, and (Correct Alleged Violation 2)-(4) nse to allegations of abuse, n, or mistreatment, the facility evidence that all alleged ughly investigated. ent further potential abuse, n, or mistreatment while the ogress.	F 60			2/27/21

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		& MEDICAID SERVICES				MB NO.	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED
		245536	B. WING_				C 03/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING				15 NORTH LYNDALE, RR 2 BOX 49 IABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 610	Continued From pa	age 6	F 6 ⁻	10			
		NT is not met as evidenced	_	-			
	facility failed to ens was thoroughly inve unknown source fo for abuse. Findings include: R2 progress note d noted a large bruise measured at 10 cm very thin. R2 admission Minir assessment dated cognitive impairme extensive assist wit walker, not steady, R2 care plan include self-transferring to	v and document review, the ure the allegation of abuse estigated for an injury of r 1 of 1 (R2) resident reviewed lated 12/1/2020 at 9:01 p.m. e noted on right bicep, n x 6.5 cm and noted skin was mum Data Set (MDS) 11/22/20, identified severe nt no behaviors, requires th activities of daily living, history of falls, pain. led R2 is often seen commode or bathroom,			F 610 PLAN OF CORRECTION Green Lea Senior Living denies it vi any federal or state regulations. Accordingly, this plan of correction of not constitute an admission or agre by the provider to the accuracy of th facts alleged or conclusions set fort the statement of deficiencies. The p corrections is prepared and/or exect solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes an correlation with the most recently completed or accomplished correct action and do not correspond chronologically to the date the facilit maintains it is in compliance with th requirements of participation, or tha corrective action was necessary.	does ement ne th in blan of cuted ive ive ty e	
	has potential altered difficulty finding wo misses parts or inter to cognitive loss; R status related to atra and to observe for medical practitione considered a vulne physical abilities, in communication skil or complaints immers skin integrity relater impaired cognition observe, document	ith walker and gait belt; ; R2 d communication problem with rds to finish thoughts and ent of incoming messages due 2 has altered cardiovascular rial fibrillation and heart failure bruising/bleeding and to notify r of abnormalities; R2 is rable adult related to impaired npaired cognitive status and lls and to report any concerns ediately; R2 has impairment to d to impaired mobility, and incontinence and to t, and report any skin injuries. daughter reported R2 has thin			 In continuing compliance with F Investigate/Prevent/Correct Alleged Violations CFR(s): 483.12(c)(2)-(4) Lea Senior Living corrected the defi by educating the Executive Director the Director of Nursing on the proce thoroughly investigating and submit investigations within 5 working days alleged violation on 2/8/21 by the Ad Nurse Specialist. To correct the deficiency and to the problem does not recur the Acc Nurse Specialist will audit all incider require state notification upon occur 	Green iciency and ess for ting of the ccura ensure ura nts that	

Facility ID: 00124

		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	. ,	G		PLETED
						С
		245536	B. WING			03/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
GREEN I	EA SENIOR LIVING			115 NORTH LYNDALE, RR 2 B MABEL, MN 55954	OX 49	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 610	Continued From pa	age 7	F 61	0		
	fragile skin and eas	sily gets skin tears and bruises.		for accuracy of investig		
	Dunin a an interview			and then monthly for 2		
lic		/ on 2/2/21 at 1:35 p.m., ourse (LPN)-A stated the aide		substantial compliance	is met.	
	was assisting resid	ent to bed and noticed a		3. As part of Green Lea		
		right arm. LPN-A stated she		commitment to quality a		
		sured the bruise. LPN-A aviors of complaining about		DNS and/or designee w concerns through the co		
		care of her even if they had		quality Assurance proce		
		her or say the staff were				
	hurting her even if not touching her. LPN-A stated she questioned the staff working and staff denied					
		ruise got there. LPN-A stated				
	she believed it was	the blood pressure cuff as it				
		id many of the residents A stated the bruise was				
		he blood pressure goes and				
	the size of the cuff.	LPN-A stated the director of				
		was notified the next day as				
		e evening and because she did use. LPN-A stated the family				
		a history of bruising easily.				
	LPN-A stated staff	were told not to take blood				
	pressure on that ar concerned of any a	m. LPN-A stated she was not buse.				
		on 2/2/21 at 2:41p.m., nurse				
		she noticed the bruise on R2 d to nurse right away. NA-A				
		e solid bruise. NA-A stated R2				
	stated she was gra but could not state	bbed when being transferred who it was.				
		on 2/2/21 at 3:31 p.m., (DON) stated she was notified				
	of the bruise the m	orning of 12/2/20 and began				
		ON stated the nurse should				
	before. DON stated	ime of the finding the night				

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		AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	no matter what time solid bruise that res of the blood pressu anyone hurting her stated no alleged p stated staff were ini- the staff had worke and if bruising was residents were not process would be to also. DON stated si staff on proper han not document the e DON stated the vul because the bruise for sure of the origin cognitively impaired During a follow up i p.m., DON confirme completed and they residents. DON stat notified of the bruis should have been r and they are to noti changes. DON stat of discovery of the s responsible for noti Vulnerable adult re occurred on 12/2/20 physical abuse of u description of injury Vulnerable report in date and time subm Department of Hea incident included re bruise 10cm x 6.5c	e. DON stated it was a large sembled the size and location re cuff. DON stated R2 denied or being rough with her. DON erpetrator was identified. DON terviewed regarding whether d with R2, how R2 transferred, observed. DON stated other interviewed. DON stated the o interview other residents he did verbal education with dling and transferring but did education with staff signatures. nerable adult report was filed occurred and was unknown n. DON stated R2 was d. nterview on 2/3/21at 12:02 ed only staff interviews were y did not interview other ted the physician was not e. DON stated the physician notified regarding the bruise fy the physician of any skin ed the nurse working at time skin change or bruise is fying the physician. port indicated incident 0 at 00:00. Of allegation of inexplained injury with y as bruise to right bicep. ndicated 12/2/20 at 13:53 as	F	610			

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		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	during routine skin of the bruise is unknow was identified. The report submitted to 12/7/20 at 4:02 p.m regarding the bruise issues that notes br notes at time of inci- documents did not duty during the time regarding possible a residents, documer notification to the pl failed to provide edu- reporting and abuse sources. Facility Vulnerable a the resident is free mistreatment, misa property and exploi unknown source su explained immediat report any maltreatu The procedure inclu- employed by facility policy definition of in included the source observed by any pe- injury could not be of the injury or the loca- reporting procedure the alleged abuse of observed, a manda- make an initial repo- securing the reside- review of the situati	age 9 check and that the cause of wn. No alleged perpetrator e facility 5 day investigation the State Agency dated a. included, interviews of staff e on R2, R2 care plan for skin ruises easily, and R2 progress ident. Facility investigation include interviews of staff abuse, interviews of staff abuse, interviews of other ntation of R2 interview, or hysician. In addition, the facility ucation on vulnerable adult e including injury of unknown Adult Policy included to ensure from abuse, neglect, ppropriation of resident tation and includes injuries of istained that is not reasonably tely. It indicated the facility will ment of a vulnerable adult. uded mandated reporters <i>y</i> shall report immediately. The njury of unknown source e of the injury was not erson or the source of the explained by the resident and ous because of the intent of ation of the injury. Internal e included that during the shift or unexplained injury is first ted reporter will immediately ort to their supervisor after nts safety and following the ion, the supervisor will to the administrator and	F	510			

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		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245536	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610 F 684 SS=D	director of nursing. supervisor of the su in question will be in placed under direct non-resident related investigation as pro included the admini shall determine if the the criteria for repor- reported immediate after forming the su supervisor, director will immediately inst of the reported alleg include interviews, resident health issu medication review. Facility Change in C guideline to initiate situation, backgroun recommendation (S physician. Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a resi that residents receiv accordance with pro- practice, the compri- care plan, and the r	It included upon report to a uspected abuse, the employee interviewed, reassigned duties, supervision, assigned to d tasks or suspended pending otection of the resident. It istrator or director of nursing he incident/allegation meets rtable incident which will be ely but no later than 2 hours uspicion. It indicated the of nursing, or administrator titute an internal investigation gation or incident which may of staff, resident interviews, environmental review, ues, behavior review, and Condition policy included the change in condition using the nd, assessment, BBAR) tool to inform the care fundamental principle that hent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered		510			2/27/21

Facility ID: 00124

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
						0	2
		245536	B. WING			02/0	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	EA SENIOR LIVING				15 NORTH LYNDALE, RR 2 BOX 49 IABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 684	Continued From pa	ge 11	F 6	84			
1 004	Based on interview facility failed to ider conditions for 1 of 3 non-pressure relate Findings include: R1's Admission Re admitted to the faci of heart failure, dru mixed incontinence R1's admission mir assessment, dated having moderately requiring extensive bed mobility, transfip personal hygiene. That as being frequently continent of bowel a R1 was at risk for d had no pressure und skin damage. R1 hat for the chair and be R1's care plan initia potential impairment to) incontinence, im goal was identified alteration/injury thro Interventions includ area and/or not pos dated 11/18/20, Ed	 And document review, the http://www.strifty.non-pressure related skin are stilled of the skin conditions. cord indicated R1 was lity on 9/20/20 with diagnoses in and bipolar disorder. and bipolar disorder. and bipolar disorder. bimum data set (MDS) 9/26/20 identified R1 as impaired cognition and assistance of two staff with ers, dressing, toileting, and The MDS further identified R1 incontinent of bladder, always and had no toileting program. Is a pressure reducing device ad. ated 9/21/20, identified R1 had to skin integrity r/t (related paired mobility, and obesity. A for R1 to be free from skin ough the review period. led: Attempt to reposition off sition on area when possible ucate, cue, and assist with ff loading dated 11/18/2020 	FO	84	F 684 PLAN OF CORRECTION Green Lea Senior Living denies it v any federal or state regulations. Accordingly, this plan of correction not constitute an admission or agree by the provider to the accuracy of the facts alleged or conclusions set for the statement of deficiencies. The p corrections is prepared and/or exect solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes ar correlation with the most recently completed or accomplished correct action and do not correspond chronologically to the date the facilit maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 684, Quality of Care CFR(s): 483 Green Lea Senior Living corrected deficiency by completing the comprehensive skin and position assessment on all residents to asses potential risk of skin alterations and plans were updated with appropriate interventions on 2/23/21. 2. To correct the deficiency and to the problem does not recur the DN educated the nursing staff on the	does eement ne th in blan of cuted nd tive ty ne at .25 the ess for I care e ensure	
	R1's body audit pro included, "Body aud	gress note dated 9/20/20 dit completed. Fingernails are Toenails are cleaned and			skin/wound process on 2/8/21. The and/or designee will audit 2 body a assessments and PCC documenta accuracy daily Monday thru Friday	udit tion for	

Facility ID: 00124

STATEMEN	F OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIPL	E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	. BUILDING			PLETED	
		0.45500					C	
		245536	B. WING			02/0	03/2021	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	Έ.		
GREEN	LEA SENIOR LIVING				15 NORTH LYNDALE, RR 2 BOX 49 IABEL, MN 55954			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 12	F 68	84				
	trimmed at this time and toes indicate th	e. Inspection of feet, ankles hey are clear. Inspection of			weeks and then randomly to maintain substantial compliance.			
		are firm. Edema present. Skin						
	VIVA towels and cr	owders to folds, please use reams "			 As part of Green Lea Senior Livi commitment to quality assurance, to 			
					DNS and/or designee will report ide			
		v on 2/1/21, at 2:51 p.m. family			concerns through the community	s QA		
		ated we had a specific lotion ⁻ cream, lantiseptic that we			Process.			
		oplied to the facility that we						
	want applied to [R1] daily underneath her folds,						
		peri area and butt to prevent						
		t was a daily care skin FM-A stated she told them not						
	•	powder on her, because it						
	breaks downs her	skin. FM-A stated when she						
		breakdown on her butt, they						
		head and got a stoma use on her butt. R1 called me						
		t hurt and I mentioned it to the						
	nurse. I told the nu	rse that sometimes when she						
		her butt they would use a						
		ixture and the facility went I the straight up stoma						
		m their pharmacy, which I had						
		. I had told them to order all						
		R1's] pharmacy and FM-A will						
		<i>I</i> -A stated R1 was supposed to ery for her cancer, we took her						
	0	have her pre operation						
	appointment done.	FM-A stated R1 started to cry						
		not want to have the surgery						
		ot want to have to go back to FM-A stated R1 stated R1 stated I see						
		not want to have the surgery.						
	FM-A stated R1 did	d not go to the appointment, we						
		and gave her a good shower						
		sores underneath her breast, ds in the peri area and her butt						
	Longenean ner (old	\sim	1					

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		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			ε	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREEN I	EA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	away on 1/28/21. Fl would have wanted would have told us of the risk of infection stated by the time w too late because the FM-A stated R1 have FM-A stated R1 have FM-A was able to h January. FM-A stated hamburger, literally had a special where to prevent breakdow reclined tilted, it did breakdown. FM-A stated hwas on her light a lo bathroom. FM-A stated the was on her light a lo bathroom. FM-A stated the mass on her light a lo bathroom. FM-A stated the state R1 was uncoop having to go to the R1's nurse progress "This nurse progress "This nurse receive [family member-A]. appointment on 11/ transporting her to took [R1] to her hor made her dinner an Also during this co reviewed and notes aides to review, the [R1's] room as well. moisture associated we possibly try to go powder to help dry to	r. FM-A stated R1 passed M-A stated even if my mom to have the surgery, they she could not have it because ons from her sores. FM-A ve got the sores healed it was e breast cancer had spread. d three very deep wounds, and leal them by around the 5th of ed R1's, "bottom was hamburger." FM-A stated She lchair chair that had gadgets wn, had special instructions, everything to prevent stated twice I went there (to the this legs were soaked, she was chair and she was soaking ney called me and told me she bot to have to go to the ated the facility did not share berative with cares other than bathroom all the time. s note dated 11/3/20 included, d a phone call on 11/3/20 from [R1] had gone out for an	F	584			

Facility ID: 00124

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245536	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	15 NORTH LYNDALE, RR 2 BOX 49		
GREENI	LEA SENIOR LIVING			N	MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From pa	qe 14	Fé	584			
	any powders used a past and they did no continue using the o	as she has used them in the ot work. [FM-A] wants staff to cream that she has supplied					
		was using at home prior to be using when she discharges					
	identification of wou	nedical record there was no unds prior to the family le skin concerns to their					
	attention on 11/3/20 skin integrity evalua	 Although the following 4 ations were completed after ney do not identify where the 					
	11/3/20, at 4:05 p.m	ntegrity Evaluation Note dated n. included, "Late Entry: Note					
	Type of alteration: N skin damage] from	ure associated skin damage] MASD [moisture associated incontinence. 2cm x1cm, No nneling is present. Tissue					
	type: Bright Pink or left blank. Drainage	Red, % of each tissue type: Amount: None, Wound edge: ached Peri-wound: Normal					
	Infection present: N treatment. Current t	lo Mild pain present during treatment: Stoma paste per s used before at home and					
	Status of wound is a 5.0 PUSH SCORE.	ic]. Treatment Effective: Yes. active. 13.0 Moderate Risk, Identified on 11/3/2020, per					
	happened before th and viva paper towe	quest, when this has ley would use stoma paste els. This was ordered and					
	skin damage] to but incontinence. [R1] r	MASD [moisture associated ttocks d/t [due to] urinary refuses to off load in bed and					
	sleep in it as well. [F	r power WC [wheelchair] and FM-A] states that this is what at cares can be performed					

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCT	ION		0. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		· · ·	MPLETED
							С
		245536	B. WING		02	2/03/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP C	ODE	
GREEN I	EA SENIOR LIVING			9			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	VIDER'S PLAN OF COF CORRECTIVE ACTION EFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	age 15	F 6	84			
		s well. this writer explained it is					
	better for staff to be	e able to see these areas to					
		when in bed. [R1] drinks 5-6					
		vell as coffee and large causing her to void frequently,					
		ill have just completed toileting					
		tes [R1] needs to go again."					
		ntegrity Evaluation Note dated					
		p.m. included, "Late Entry: moisture associated skin					
		Iteration: MASD [moisture					
		mage] from incontinence,					
	0.6cm x 0.5cm. No	undermining. No tunneling is					
		e: Bright Pink or Red % of					
		eft blank. Drainage Amount:					
		: Distint [sic] and Attached al Infection present: No Mild					
		treatment. Current treatment:					
		M-A's] request as used before					
		apertowels [sic]. Treatment					
		us of wound is active. 13.0					
		PUSH SCORE. Identified on					
		ghter [FM-A] request, when before they would use stoma					
		er towels. This was ordered					
		sted. MASD [moisture					
		mage] to buttocks d/t [due to]					
		e. [R1] refuses to off load in					
		o sit in her power WC eep in it as well. [FM-A] states					
		1] prefers and that cares can					
		in her chair as well. this writer					
	explained it is bette	er for staff to be able to see					
		t and measure when in bed.					
		as per day as well as coffee					
		of water causing her to void nes staff will have just					
		and within 10 minutes [R1]					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245536	B. WING	i			C 0 3/2021
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN L	EA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	11/3/2020, at 4:15 p MASD [moisture as of alteration: MASD damage] from intert skin areas may touc 0.2cm, No undermii Tissue type: Bright type: Left blank. Dra Wound edge: Distir Peri-wound: Norma pain present during stoma paste and viv request as done at Treatment Effective active. 14.0 Modera Identified on 11/3/2 this has happened I paste and viva pape and used as reques associated skin dar urinary incontinence bed and requests to [wheelchair] and sle that this is what [R1 be performed while explained it is bette these areas to treat [R1] drinks 5-6 soda and large amounts frequently, many tim completed toileting needs to go again."	htegrity Evaluation Note dated o.m. included, "Late Entry: sociated skin damage] Type [moisture associated skin triginous [An area where to ch or rub together]. 3cm x ning. No tunneling is present. Beefy Red. % of each tissue ainage Amount: Scant Serous. At [sic] and Attached. I. Infection present: No. Mild treatment. Current treatment: va paper towels per [FM-A's] home prior to admit. e: Yes. Status of wound is te Risk, 5.0 PUSH SCORE. 020, per [FM-A] request, when before they would use stoma er towels. This was ordered sted. MASD [moisture nage] to buttocks d/t [due to] e. [R1] refuses to off load in o sit in her power WC eep in it as well. [FM-A] states] prefers and that cares can in her chair as well. this writer r for staff to be able to see and measure when in bed. as per day as well as coffee of water causing her to void nes staff will have just and within 10 minutes [R1]	F	684	4		
	11/3/2020, at 4:21p	.m. included, "Late Entry: sociated skin damage] Type					

Facility ID: 00124

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		AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF	PROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	of alteration: MASD damage] from inter skin areas may tou 0.2cm. No undermi Tissue type: Bright type: Left blank. Dra Wound edge: Distir Peri-wound: Norma pain present during stoma paste and vir [FM-A], as this is w admit. Treatment E is active. 14.0 Mode Identified on 11/3/2 when this has happ stoma paste and vir ordered and used a associated skin dar urinary incontinence bed and requests to [wheelchair] and ske that this is what [R1 be performed while explained it is bette these areas to treat [R1] drinks 5-6 sod and large amounts frequently, many tir completed toileting needs to go again. R1's progress noted [treatment] with cre breast and buttocks paper towel for wich powders, corn stard	 D [moisture associated skin triginous [An area where to ch or rub together]. 2cm x aning. No tunneling is present. Beefy Red. % of each tissue ainage Amount: Scant Serous. It [sic] and Attached. al. Infection present: No. Mild treatment. Current treatment: va paper towel as request by that they did at hoe [sic] prior to the eater Risk. 5.0 PUSH SCORE. b) (20, per [FM-A's] request, bened before they would use va paper towels. This was as requested. MASD [moisture mage] to buttocks d/t [due to] e. [R1] refuses to off load in o sit in her power WC eep in it as well. [FM-A] states 1] prefers and that cares can e in her chair as well. this writer er for staff to be able to see t and measure when in bed. as per day as well as coffee of water causing her to void mes staff will have just and within 10 minutes [R1] d date 11/4/20 included, "TX eam applied to abdominal, s (family provides.), with viva king. Family requests no ch or nystatin be used for 	F	684			

Facility ID: 00124

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		AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245536	B. WING				C 03/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	included, "Body aud clean and trimmed. trimmed at this time and toes indicate they Breast folds improve open areas, abdom small opening scan Right side abdomin scant serosanguine folds improving. Bu noted bilateral, scan R1's Skin/Wound N little pink under bila -Anterior abdomina each have small op maceration/sheerin R1's Skin/Wound N "Both areas on butt increased, see wou discussion with [FN stoma paste will be [sic] cream and nor [FM-A] will call or vi wounds." R1's Weekly Skin In 11/9/20, at 4:26 p.m associated skin dar MASD [moisture as incontinence. 0.75 c tunneling is present Red. % of each tiss Amount: None Wou Attached. Peri-woul No. Mild pain prese	dit completed. Fingernails are . Toenails are cleaned and e. Inspection of feet, ankles ney are clear. Inspection of are firm. Edema present. ved slight pink beneath, no ninal folds lower front area with at amount serosanguineous. hal fold small open area with eous drainage. Abdominal ttock maceration/sheering nt serous drainage present. Note dated 11/8/20 included, "A tt [sic] breasts. No open areas. I fold and right abdominal fold ben areaBilateral buttock	F	584			

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		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245536	B. WING	;			C 03/2021
NAME OF	PROVIDER OR SUPPLIER			Ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	[dressing]. Treatme wound is active.14. SCORE. Over the w viva paper towels w was difficult and pa areas. [R1] refused nurse RN-A] spoke wasted [sic] the lan being applied and a prevent sticking, are measurements hav R1's Weekly Skin In 11/9/20, at 4:33p.m associated skin dar MASD [moisture as incontinence. 3cm of tunneling is present Red % of each tisse Amount: None. Wo Attached. Peri-wour No. Mild pain prese treatment: lanispeti [dressing]. Treatme wound is active.14. SCORE. Over the w viva paper towels w was difficult and pa areas. [R1] refused nurse RN-A] spoke wasted [sic] the lan being applied and a prevent sticking. are measurements." R1's Weekly Skin In 11/9/20, at 4:43p.m associated skin dar MASD [moisture as	ent Effective: Yes Status of 0 Moderate Risk. 3.0 PUSH weekend the stoma paste and vere creating a thick paste that inful when removed form the stoma paste, [register with [FM-A] and [FM-A] iseptic cream used, this is a telfa drsg [dressing] to ea is healing and	F	684			

Facility ID: 00124

If continuation sheet Page 20 of 27

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8					FORM	03/08/2021 APPROVED 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
	245536	B. WING	i			C 03/2021
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
each tissue type: Leff None. Wound edge: Peri-wound: Normal. pain present during tr Stoma paste per [FM at home and viva pape Effective: Yes. Status Moderate Risk. 5.0 P weekend the stoma p were creating a thick painful when removed the stoma paste, [reg with [FM-A] and [FM- cream used, this is bo [dressing] to prevent larger in measurement R1's Weekly Skin Inte 11/9/20, at 4:45p.m. i associated skin dama MASD [moisture asso incontinence. 0.6cm of No tunneling is prese or Red. % of each tis Drainage Amount: No [sic] and Attached. Per present: No. Mild pain Current treatment: tre laniseptic and telfa. T Status of wound is ac PUSH SCORE Over paste and viva paper paste that was difficu form areas. [R1] refus [FM-A] wasted [sic] th	 Bright Pink or Red % of t blank. Drainage Amount: Distint [sic] and Attached. Infection present: No. Mild reatment. Current treatment: I-A's] request as used before pertowels [sic]. Treatment s of wound is active.13.0 PUSH SCORE. Over the paste and viva paper towels paste that was difficult and d form areas. [R1] refused gister nurse RN-A] spoke -A] wasted [sic] the laniseptic eeing applied and a telfa drsg sticking. Area is slightly ents." regrity Evaluation Note dated included, "MASD [moisture age] Type of alteration: ociated skin damage] from x 0.5cm. No undermining. ent. Tissue type: Bright Pink esue type: Left blank. one. Wound edge: Distint eri-wound: Normal. Infection n present during treatment. eatment changed to Treatment Effective: Yes ctive.13.0 Moderate Risk. 3.0 the weekend the stoma towels were creating a thick alt and painful when removed used the stoma paste,] spoke with [FM-A] and he laniseptic cream used, and a telfa drsg [dressing] to 	F	684			

If continuation sheet Page 21 of 27

		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATI COM	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN L	EA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From pa measurements.	ge 21	Fe	684	4		
	"RECAPITULATIOI female came to the need for back surge able to make her ne and uses both sche medications. Current the buttocks. The a	dated 11/12/20 included, N OF STAY: [R1] a 80 year old facility due to the daughters ery. She is very pleasant and eeds known. Her pain varies eduled and as needed pain ntly the only skin issue is on bdominal fold is currently r. She continues with oxygen ome with her own					
	included, "Body aud clean and trimmed. trimmed at this time and toes indicate th heels indicate they Abdomen folds are	gress note dated 11/13/20 dit completed. Fingernails are Toenails are cleaned and e. Inspection of feet, ankles ney are clear. Inspection of are firm. Edema present. not open and pink in color. easts are intact color darker					
	has left the facility v go home. She was Using the facilities p transferred to the fr	dated 11/16/20 included, [R1] with her [Family members] to in her electric wheelchair. portable oxygen tank. She ont passengers [sic] seat with er [family member]."					
	nursing assistant (N assist with a gait be wheelchair, and sta her. NA-D stated R her breasts, in the g	on 2/2/21, at 1:49 p.m. NA)-D stated R1 required two elt, had a motorized ff did most of the cares for 1 got yeast infections under groin area and had fold area by applied a cream that she					

Facility ID: 00124

If continuation sheet Page 22 of 27

		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245536	B. WING				C 03/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	used at home. NA-I incontinent. NA-D s two hours, and she to go to toilet but sta just not hold it. NA- as often as she nee stated R1 was repo she would also get get up to the comm had been here quite bed. NA-D stated R wheelchair. NA-D s herself in the wheel of her chair. NA-D s concerns when we residents up, during NA-D stated when completed a skin cl report to the nurse and have the nurse and have the nurse During an interview licensed practical n very pleasant lady, not like to lay down incontinent. LPN-C right, she was on La she came, she brou wear in her underw through these. LPN wheelchair and she reposition. LPN-C stay R1 started to g repositioning. LPN- her needs known. L R1 out of the facility her home and gave brought her back, I	D stated R1 was very stated they toileted R1 every would call when she needed ated sometimes, she could D stated we would change her eded to be changed. NA-D ositioned every two hours and repositioned when she would ode. NA-D stated after she e a while, she would get into a preferred to be in her stated R1 could repositioned lochair and changed positions stated staff monitor for skin do cares, washing up g peri-cares and toileting. we give them a bath the nurse heck. NA-D stated she would right away any changes in skin	F	584			

Facility ID: 00124

If continuation sheet Page 23 of 27

		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMI	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF I	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	with [FM-A] that day the skin assessmer LPN-C stated the a and I recall reportin were not there." LP the family had any of after that outing wh reported the skin co stated on bath days assessment on a w During an interview licensed practical n new wound or skin had the director of n she started a wound documentation. LPI the area, measured to treat it and notified the floor staff docur daily and DON com assessments. LPN- family are notified. I look at the wound of documentation and on bath day. At 9:20 became aware of R took R1 out of the f LPN-B stated the D repositioning and ke we passed along th importance of reposi- During an interview director of nursing (going to the bathroo was what we were there as her goal was	y LPN-C said she had done nt and her skin was intact. reas were like little, tiny slits g to the DON, "I swear those N-C stated she did not know concerns about her cares until en family gave R1 a bath and oncerns to the facility. LPN-C s nurses completed skin	F	584			

If continuation sheet Page 24 of 27

STATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		A. BUILDIN		C				
		245536	B. WING _			/03/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
GREEN	LEA SENIOR LIVING			115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 684	hours. The DON st it (reposition)on he wheelchair back ar frequently. The DO in wheelchair as ne The DON stated ty the am, pm and du notify the nurse if th that could be a con document skin con (PCC). The DON s call from FM-A that concerns in PCC [F medical record]. Th a skin assessment areas that were of there were four are abdominal folds that areas on each butt were identified by F home. The DON st building for an once decided to not have took her home. The a spa day and that areas. The DON st identified she comp assessments and t was completed by facility put up a whi documented times on the board. The I the open areas FM we asked the doctor	age 24 ated to an extent R1 could do r own, she could tilt her nd she could adjust herself N stated staff would boost R1 eeded with an assist of two. pically aides observe skin in ring prn cares. The aides hey see anything not normal ocern and they would also ditions in point click care tated she received a phone t day she documented the skin Point Click Care-electronic ne DON stated she completed and took measurements of concern. The DON stated eas, one on each side of at were small slits and small ock. The DON stated all areas FM-A the day family took her tated family had her out of the ology appointment and R1 e any more treatment and they e DON stated family gave her is when they found the open tated she had just taken over complete an investigation to facility missed seeing the open tated when a skin concern was obted weekly wound the daily wound documentation the nurse. The DON stated the ite board in R1's room and of toileting and repositioning DON stated stoma paste, so or for an order for stoma paste t. The DON stated we used	F 68					

If continuation sheet Page 25 of 27

		I AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245536	B. WING	i			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	EA SENIOR LIVING				115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	DON stated we sug it up and FM-A said powders. The DON the stoma paste an we got the Stoma p we could start using the facility only com measurements of th discharged to home would have been co DON stated she wo to have identified th was brought to her stated after the con FM-A she was awa cares and stated th found was a big con talked with nurses of importance of repose the moisture away fi identified skin areas make the staff awa with this situation. T they did reposition a DON stated she wa water, so she was of and was also on flu did explain to FM-A repositioning and on identified, she was repositioning and w The Skin Managem procedure revised F residents will be assi-	eally helping anything. The ggested nystatin powder to dry d absolutely no nystatin or stated FM-A wanted us to get d get it on (start treatment), so paste from our pharmacy so g it that night. The DON stated	F	584			

If continuation sheet Page 26 of 27

		AND HUMAN SERVICES				FORM	: 03/08/2021 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		CON	TE SURVEY IPLETED
		245536	B. WING				C /03/2021
NAME OF	PROVIDER OR SUPPLIER			SS, CITY, STATE, ZIP COD			
GREEN LEA SENIOR LIVING			115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH	VIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE

Facility ID: 00124



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 18, 2021

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

Re: State Nursing Home Licensing Orders Event ID: 1S3E11

Dear Administrator:

The above facility was surveyed on February 2, 2021 through February 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

Green Lea Senior Living February 18, 2021 Page 2

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

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

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

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

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

Please feel free to call me with any questions.

M. Pig

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

Minnesc	ta Department of He	alth				/ I I KOVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00124	B. WING		02/0	C)3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	LEA SENIOR LIVING		TH LYNDALE MN 55954	E, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted to detern Licensure. Your fac compliance with the indicate in your elec you have reviewed date when they will	21, an abbreviated survey was nine compliance with State ility was found to be NOT in MN State Licensure. Please ctronic plan of correction that these orders, and identify the				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	INATURE	TITLE		(X6) DATE 02/26/21

Electronically Signed

If continuation sheet 1 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00124			(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		B. WING		02/03/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GREEN	LEA SENIOR LIVING	115 NORT MABEL, M		, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: order issued at S46 The following comp UNSUBSTANTIAT The facility is enroll signature is not req page of state form. Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested Time period for Con You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for State heading completion be corrected prior to	Alaint was found to be ED: H5536005C. ed in ePOC and therefore a uired at the bottom of the first nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for the assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rection. to participate in the electronic nsure orders consistent with artment of Health tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

1S3E11

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION ()	K3) DATE SURVEY COMPLETED C
00124		B. WING	02/03/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GREEN	LEA SENIOR LIVING		TH LYNDALI MN 55954	E, RR 2 BOX 49	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
2 000	Continued From pa	ge 2	2 000		
		and therefore a signature is bottom of the first page of			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.			
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830		2/27/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	I t		
	by: Based on interview facility failed to iden	ent is not met as evidenced and document review, the tify non-pressure related skin residents (R1) reviewed for ed skin conditions.		S 2830 MN Rule 4658.0520 Subp. 1 Adequa and Proper Nursing Care; General 1. Corrected.	ate
		cord indicated R1 was lity on 9/20/20 with diagnoses			

STATE FORM

1S3E11

If continuation sheet 3 of 18
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00124	B. WING		C 02/03/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN	LEA SENIOR LIVING		TH LYNDALE MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 3	2 830			
		of heart failure, drug induced Parkinsonism, mixed incontinence and bipolar disorder.				
	having moderately in requiring extensive a bed mobility, transfe personal hygiene. Th as being frequently in continent of bowel an R1 was at risk for de had no pressure ulce	9/26/20 identified R1 as impaired cognition and assistance of two staff with ers, dressing, toileting, and The MDS further identified R1 incontinent of bladder, always and had no toileting program. leveloping pressure ulcers and cers or moisture associated ad a pressure reducing device	1			
	potential impairmento) incontinence, im goal was identified alteration/injury through Interventions include area and/or not post dated 11/18/20, Ed	ated 9/21/20, identified R1 had nt to skin integrity r/t (related npaired mobility, and obesity. A for R1 to be free from skin ough the review period. ded: Attempt to reposition off sition on area when possible ucate, cue, and assist with ff loading dated 11/18/2020 nent.				
	included, "Body aud clean and trimmed trimmed at this time and toes indicate th heels indicate they	ogress note dated 9/20/20 dit completed. Fingernails are . Toenails are cleaned and e. Inspection of feet, ankles ney are clear. Inspection of are firm. Edema present. Skin owders to folds, please use eams."				
	member (FM)-A sta and a water barrier	on 2/1/21, at 2:51 p.m. family ated we had a specific lotion cream, lantiseptic that we plied to the facility that we				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED
					с	
		00124	B. WING		02/03/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GREEN	LEA SENIOR LIVING		TH LYNDALE MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830			
	under her breasts, skin break down. It protectant cream. It to use any kind of p breaks downs her s started to get skin I (the facility) went a adhesive paste to u and told me her bu nurse. I told the nu had breakdown on stoma adhesive mi ahead and ordered adhesive paste fron told them not to do prescription from [F bring it to them. FM have a breast surg out of the facility to appointment done. and stated she did because she did no the nursing home. how they live; I do n FM-A stated R1 did brought her home a and we saw these underneath her fold look like hamburge away on 1/28/21. F would have wanted would have told us of the risk of infecti stated by the time w too late because th FM-A stated R1 ha FM-A stated R1 ha FM-A stated R1 ha	[] daily underneath her folds, peri area and butt to prevent was a daily care skin FM-A stated she told them not powder on her, because it skin. FM-A stated when she breakdown on her butt, they head and got a stoma use on her butt. R1 called me t hurt and I mentioned it to the rse that sometimes when she her butt they would use a xture and the facility went I the straight up stoma m their pharmacy, which I had . I had told them to order all R1's] pharmacy and FM-A will M-A stated R1 was supposed to ery for her cancer, we took her have her pre operation FM-A stated R1 started to cry not want to have the surgery of want to have the surgery. I not go to the appointment, we and gave her a good shower sores underneath her breast, ds in the peri area and her butt fr. FM-A stated R1 passed in the very deep wounds, and heal them sores. FM-A we got the sores healed it was the breast cancer had spread. I three very deep wounds, and heal them by around the 5th of ted R1's, "bottom was a part of the surgery."				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00124	(X2) MULTIPLE A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 02/03/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• •	
GREEN	LEA SENIOR LIVING		TH LYNDALE, MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	had a special whee to prevent breakdow reclined tilted, it did breakdown. FM-A s facility) and her par sitting there in her of wet. FM-A stated th was on her light a lo bathroom. FM-A stated th review [R1's nurse progress. "This nurse receive [family member-A]. appointment on 11/ transporting her to took [R1] to her hor made her dinner an Also during this of reviewed and notes aides to review, the [R1's] room as well moisture associated we possibly try to g powder to help dry her folds. [FM-A] sta any powders used a past and they did no continue using the admission and will h home." According to R1's m identification of wou member bringing th attention on 11/3/20	Ichair chair that had gadgets wn, had special instructions, everything to prevent stated twice I went there (to the stated twice I went there (to the stated twice I went there (to the stated twice I went there (to the schair and she was soaking ney called me and told me she bet to have to go to the ated the facility did not share berative with cares other than bathroom all the time. s note dated 11/3/20 included, d a phone call on 11/3/20 from [R1] had gone out for an				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	- (X3) DATE SURV COMPLETED C	
		00124	B. WING		02/	03/2021
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GREEN	LEA SENIOR LIVING		MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			
2 830	Continued From pa	ige 6	2 830			
	FM-A phone call, they do not identify where the wounds were located.					
	11/3/20, at 4:05 p.n Text: MASD [moist Type of alteration: I skin damage] from undermining. No tu type: Bright Pink or left blank. Drainage Distint [sic] and Atta Infection present: N treatment. Current [FM-A's] request as viva papertowels [s Status of wound is 5.0 PUSH SCORE. daughter [FM-A] ref happened before th and viva paper towo used as requested. skin damage] to bu incontinence. [R1] r requests to sit in he sleep in it as well. [I [R1] prefers and tha while in her chair as better for staff to be treat and measure sodas per day as w amounts of water c many times staff wi and within 10 minut R1's Weekly Skin In 11/3/2020, at 4:12 p Note Text: MASD [i damage] Type of al	ntegrity Evaluation Note dated n. included, "Late Entry: Note ure associated skin damage] MASD [moisture associated incontinence. 2cm x1cm, No nneling is present. Tissue Red, % of each tissue type: a Amount: None, Wound edge: ached Peri-wound: Normal lo Mild pain present during treatment: Stoma paste per s used before at home and ic]. Treatment Effective: Yes. active. 13.0 Moderate Risk, . Identified on 11/3/2020, per quest, when this has ney would use stoma paste els. This was ordered and MASD [moisture associated ttocks d/t [due to] urinary refuses to off load in bed and er power WC [wheelchair] and FM-A] states that this is what at cares can be performed s well. this writer explained it is a able to see these areas to when in bed. [R1] drinks 5-6 vell as coffee and large ausing her to void frequently, ill have just completed toileting tes [R1] needs to go again."				

STATEMEN	Ita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		00124	B. WING	B. WING		C 03/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE				
GREEN LEA SENIOR LIVING 115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954								
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT					
2 830		ige 7 undermining. No tunneling is	2 830					
	present. Tissue type each tissue type: Le None Wound edge Peri-wound: Norma pain present during Stoma paste per [F at home and viva p Effective: Yes Statu Moderate Risk, 5.0 11/3/2020, per dau this has happened paste and viva pape and used as reques associated skin dar urinary incontinence bed and requests to [wheelchair] and ske that this is what [R1 be performed while explained it is bette these areas to treat [R1] drinks 5-6 sod and large amounts frequently, many tir completed toileting needs to go again."	e: Bright Pink or Red % of eft blank. Drainage Amount: : Distint [sic] and Attached al Infection present: No Mild treatment. Current treatment: M-A's] request as used before apertowels [sic]. Treatment us of wound is active. 13.0 PUSH SCORE. Identified on ghter [FM-A] request, when before they would use stoma er towels. This was ordered sted. MASD [moisture mage] to buttocks d/t [due to] e. [R1] refuses to off load in o sit in her power WC eep in it as well. [FM-A] states I] prefers and that cares can in her chair as well. this writer of or staff to be able to see t and measure when in bed. as per day as well as coffee of water causing her to void nes staff will have just and within 10 minutes [R1]						
	MASD [moisture as of alteration: MASD damage] from inter skin areas may tou 0.2cm, No undermi Tissue type: Bright type: Left blank. Dr	ssociated skin damage] Type (moisture associated skin triginous [An area where to ch or rub together]. 3cm x ning. No tunneling is present. Beefy Red. % of each tissue ainage Amount: Scant Serous.						
	Peri-wound: Norma	nt [sic] and Attached. al. Infection present: No. Mild I treatment. Current treatment:						

ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 02/03/2021	
				02/	03/2021
PROVIDER OR SUPPLIER					
EA SENIOR LIVING			RR 2 BOX 49		
SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 8	2 830			
Treatment Effective active.14.0 Modera Identified on 11/3/2 this has happened paste and viva pape and used as reques associated skin dar urinary incontinence bed and requests to [wheelchair] and sle that this is what [R1 be performed while explained it is better these areas to treat [R1] drinks 5-6 sod and large amounts frequently, many tin completed toileting needs to go again."	e: Yes. Status of wound is te Risk, 5.0 PUSH SCORE. 020, per [FM-A] request, when before they would use stoma er towels. This was ordered sted. MASD [moisture mage] to buttocks d/t [due to] e. [R1] refuses to off load in o sit in her power WC eep in it as well. [FM-A] states I] prefers and that cares can in her chair as well. this writer r for staff to be able to see t and measure when in bed. as per day as well as coffee of water causing her to void nes staff will have just and within 10 minutes [R1]				
11/3/2020, at 4:21p MASD [moisture as of alteration: MASD damage] from inter skin areas may toue 0.2cm. No undermi Tissue type: Bright type: Left blank. Dra	o.m. included, "Late Entry: sociated skin damage] Type (moisture associated skin triginous [An area where to ch or rub together]. 2cm x ning. No tunneling is present. Beefy Red. % of each tissue ainage Amount: Scant Serous.				
Peri-wound: Norma pain present during stoma paste and vir [FM-A], as this is wir admit. Treatment E	II. Infection present: No. Mild treatment. Current treatment: va paper towel as request by hat they did at hoe [sic] prior to ffective: Yes. Status of wound				
	OF CORRECTION PROVIDER OR SUPPLIER LEA SENIOR LIVING SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From parts stoma paste and vir request as done at Treatment Effective active. 14.0 Moderal Identified on 11/3/2 this has happened paste and viva pape and used as request associated skin dar urinary incontinence bed and requests to [wheelchair] and sle that this is what [R4 be performed while explained it is better these areas to treat [R1] drinks 5-6 sod and large amounts frequently, many tir completed toileting needs to go again." R1's Weekly Skin In 11/3/2020, at 4:21p MASD [moisture as of alteration: MASE damage] from inter skin areas may tou 0.2cm. No undermit Tissue type: Bright type: Left blank. Draw Wound edge: Distir Peri-wound: Norma pain present during stoma paste and vi [FM-A], as this is w admit. Treatment E	OF CORRECTION IDENTIFICATION NUMBER: 00124 00124 PROVIDER OR SUPPLIER STREET AI LEA SENIOR LIVING 115 NOR MABEL, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 Stoma paste and viva paper towels per [FM-A's] request as done at home prior to admit. Treatment Effective: Yes. Status of wound is active. 14.0 Moderate Risk, 5.0 PUSH SCORE. Identified on 11/3/2020, per [FM-A] request, when this has happened before they would use stoma paste and viva paper towels. This was ordered and used as requested. MASD [moisture associated skin damage] to buttocks d/t [due to] urinary incontinence. [R1] refuses to off load in bed and requests to sit in her power WC [Wheelchair] and sleep in it as well. [FM-A] states that this is what [R1] prefers and that cares can be performed while in her chair as well. this writer explained it is better for staff to be able to see these areas to treat and measure when in bed. [R1] drinks 5-6 sodas per day as well as coffee and large amounts of water causing her to void frequently, many times staff will have just completed toileting and within 10 minutes [R1] needs to go again." R1's Weekly Skin Integrity Evaluation Note dated 11/3/2020, at 4:21p.m. included, "Late Entry: MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from intertriginous [An area where to skin areas may touch or rub together]. 2cm x 0.2cm. No undermining. No tunneling is present. Tissue type: Enght Beefy Red. % of each tissue type: Left blank. Drainage Amount: Scant Serous. Wound edge: Distint [sic] and Attached. Pe	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00124 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER OR UPULER ID SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 8 2 830 stoma paste and viva paper towels per [FM-A'S] PREFIX request as done at home prior to admit. Treatment Effective: Yes, Status of wound is active. 14.0 Moderate Risk, 5.0 PUSH SCORE. Identified on 11/3/2020, per [FM-A] request, when this has happened before they would use stoma associated skin damage] to buttock adt [due to] urinary incontinence. [R1] refuses to off load in bed and requests to sit in her power WC [Wheelchair] and sleep in it as well. [FM-A] states that this is what [R1] prefers and that cares can be performed while in her chair as well. this writer explained it is better for staff to be able to see these areas to treat and measure when in bed. [R1] drinks 5-6 sodas per day as well as coffee and large amounts of water causing her to void frequently, many times staff will have just completed tolleiting and within 10 minutes [R1] needs to go again." R1's Weekly Skin Integrity Evaluation Note dated 11/3/2020, at 4:21p.m. included, "Late Entry: MASD [moisture associated skin damage] Type of alteration: MASD [OF CORRECTION IDENTIFICATION NUMBER: A BULDING: COM 00124 B. WING 02// PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IS NORTH LYNDALE, RR 2 BOX 49 MABEL, NN 55954 MABEL, NN 55954 PROVIDER'S PLAN OF CORRECTION NUMBER: ID PREFX LEACH DEFICIENCY ON LSC DEMTFYING INFORMATION) ID REQUATORY ON LSC DEMTFYING INFORMATION) PREFX CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY ONLSC DEMTFYING INFORMATION) Continued From page 8 2 830 2 830 CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Stoma paste and viva paper towels per [FM-A'S] request as done at home prior to admit. Trag CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Continued From page 8 2 830 2 830 CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Continued From page 8 2 830 2 830 Stoma paste and viva paper towels per [FM-A'S] request as done at home prior to admit. CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Identified on 11/3/2020, per [FM-A] request, when this has happened before and that cares can be performed while in her chair as well. CROSS-REFERENCE R1's Weekly Skin Integrity Evaluation Note dated 11/3/2020, at 4:21 p.m. included, "Late Entry: MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from intertriginous [An area where to skin areas may touch or rub together]. 2cm x 0.2cm. Nu undermining. Nu tunneling is present. Tissue type: Left blank, Erianage Amount: Sca

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:				
		00124	B. WING			C 02/03/2021	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GREEN L	EA SENIOR LIVING		TH LYNDALE, MN 55954	, RR 2 BOX 49			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 9	2 830				
	ordered and used a associated skin dar urinary incontinence bed and requests to [wheelchair] and sle that this is what [R1 be performed while explained it is bette these areas to treat [R1] drinks 5-6 sod and large amounts frequently, many tin completed toileting needs to go again.	va paper towels. This was as requested. MASD [moisture mage] to buttocks d/t [due to] e. [R1] refuses to off load in o sit in her power WC eep in it as well. [FM-A] states I] prefers and that cares can in her chair as well. this writer of r staff to be able to see t and measure when in bed. as per day as well as coffee of water causing her to void nes staff will have just and within 10 minutes [R1]					
	[treatment] with cre breast and buttocks paper towel for wich	d date 11/4/20 included, "T> am applied to abdominal, s (family provides.), with viva king. Family requests no ch or nystatin be used for ns."	(
	included, "Body aud clean and trimmed. trimmed at this time and toes indicate the heels indicate they Breast folds improv open areas, abdom small opening scan Right side abdomin scant serosanguine folds improving. Bu	gress note dated 11/6/20 dit completed. Fingernails are Toenails are cleaned and e. Inspection of feet, ankles ney are clear. Inspection of are firm. Edema present. red slight pink beneath, no ninal folds lower front area with at amount serosanguineous. al fold small open area with eous drainage. Abdominal ttock maceration/sheering nt serous drainage present.					
	little pink under bila	lote dated 11/8/20 included, " <i>A</i> t [sic] breasts. No open areas. I fold and right abdominal fold					

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00124	B. WING		C 02/03/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
		115 NOR	TH LYNDALE	, RR 2 BOX 49		
GREEN	LEA SENIOR LIVING	MABEL,	MN 55954			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLETI DATE
				DEFICIENC	CY)	
2 830	Continued From pa	ge 10	2 830			
	each have small op maceration/sheerin	en areaBilateral buttock g present."				
	R1's Skin/Wound Note dated 11/8/20 included, "Both areas on buttock measurements have increased, see wound book. After lengthy discussion with [FM-A], it was decided that the stoma paste will be discontinued and lantispetic [sic] cream and non-stick pad will be used. [FM-A] will call or visit on 11/10/20 to assess the wounds."					
	11/9/20, at 4:26 p.m associated skin dar MASD [moisture as incontinence. 0.75 x tunneling is present Red. % of each tiss Amount: None Wou Attached. Peri-wou No. Mild pain prese treatment: Lanisept [dressing]. Treatme wound is active.14. SCORE. Over the w viva paper towels w was difficult and pa areas. [R1] refused nurse RN-A] spoke wasted [sic] the lan being applied and a prevent sticking, are measurements hav R1's Weekly Skin II 11/9/20, at 4:33p.m	e improved." ntegrity Evaluation Note dated . included, "MASD [moisture				
	MASD [moisture as incontinence. 3cm)	nage] Type of alteration: sociated skin damage] from k 1cm. No undermining. No t. Tissue type: Bright Pink or				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		00124	B. WING			03/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE				
GREEN	LEA SENIOR LIVING		TH LYNDALE, MN 55954	RR 2 BOX 49				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT				ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Red % of each tisse Amount: None. Wo Attached. Peri-wour No. Mild pain prese treatment: lanispetie [dressing]. Treatme wound is active.14.1 SCORE. Over the v viva paper towels w was difficult and pai areas. [R1] refused nurse RN-A] spoke wasted [sic] the lan being applied and a prevent sticking. are measurements." R1's Weekly Skin In 11/9/20, at 4:43p.m associated skin dar MASD [moisture as incontinence. No un present. Tissue type: Le None. Wound edge Peri-wound: Norma pain present during Stoma paste per [F at home and viva pain Effective: Yes. State Moderate Risk. 5.0 weekend the stoma were creating a thic painful when remove the stoma paste, [re with [FM-A] and [FM cream used, this is	Le type: Left blank. Drainage und edge: Distint [sic] and nd: Normal Infection present: nt during treatment. Current c cream and telfa drsg int Effective: Yes. Status of 0 Moderate Risk. 6.0 PUSH veekend the stoma paste and vere creating a thick paste that inful when removed form the stoma paste, [registered with [FM-A] and [FM-A] iseptic cream used, this is a telfa drsg [dressing] to ea is slightly larger in the stoma paste, [registered with [FM-A] and [FM-A] iseptic cream used, this is a telfa drsg [dressing] to ea is slightly larger in the stoma paste [from ndermining. No tunneling is e: Bright Pink or Red % of efft blank. Drainage Amount: :: Distint [sic] and Attached. I. Infection present: No. Mild treatment. Current treatment: M-A's] request as used before apertowels [sic]. Treatment us of wound is active.13.0 PUSH SCORE. Over the a paste and viva paper towels ik paste that was difficult and red form areas. [R1] refused egister nurse RN-A] spoke <i>I</i> -A] wasted [sic] the laniseptic being applied and a telfa drsg at sticking. Area is slightly						

1S3E11

If continuation sheet 12 of 18

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		COMI	E SURVEY PLETED
		00124	B. WING		C 02/03/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GREEN I	EA SENIOR LIVING		TH LYNDALE MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	R1's Weekly Skin II 11/9/20, at 4:45p.m associated skin dar MASD [moisture as incontinence. 0.6cm No tunneling is pres or Red. % of each to Drainage Amount: I [sic] and Attached. present: No. Mild p Current treatment: laniseptic and telfa. Status of wound is PUSH SCORE Ove paste and viva pap paste that was diffic form areas. [R1] re [register nurse RN- [FM-A] wasted [sic] this is being applied prevent sticking. ar measurements. R1's progress note "RECAPITULATIO	ntegrity Evaluation Note dated in included, "MASD [moisture mage] Type of alteration: associated skin damage] from in x 0.5cm. No undermining, sent. Tissue type: Bright Pink tissue type: Left blank. None. Wound edge: Distint Peri-wound: Normal. Infection ain present during treatment. treatment changed to Treatment Effective: Yes active.13.0 Moderate Risk. 3.0 er the weekend the stoma er towels were creating a thick cult and painful when removed fused the stoma paste, A] spoke with [FM-A] and the laniseptic cream used, d and a telfa drsg [dressing] to ea is slightly larger in dated 11/12/20 included, N OF STAY: [R1] a 80 year old				
	need for back surge able to make her ne and uses both sche medications. Curre the buttocks. The a	facility due to the daughters ery. She is very pleasant and eeds known. Her pain varies eduled and as needed pain ntly the only skin issue is on bdominal fold is currently or. She continues with oxygen ome with her own				
	included, "Body aud clean and trimmed. trimmed at this time	gress note dated 11/13/20 dit completed. Fingernails are Toenails are cleaned and e. Inspection of feet, ankles ney are clear. Inspection of				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00124			02/03/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GREEN I	LEA SENIOR LIVING		TH LYNDALE <u>.</u> MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 13	2 830			
	Abdomen folds are	are firm. Edema present. not open and pink in color. easts are intact color darker				
	has left the facility of go home. She was Using the facilities transferred to the fr	dated 11/16/20 included, [R1] with her [Family members] to in her electric wheelchair. portable oxygen tank. She ront passengers [sic] seat with er [family member]."				
	nursing assistant (N assist with a gait be wheelchair, and sta her. NA-D stated R her breasts, in the g concerns where the used at home. NA-l incontinent. NA-D s two hours, and she to go to toilet but st just not hold it. NA- as often as she nee stated R1 was repor- she would also get get up to the comm had been here quitt bed. NA-D stated R wheelchair. NA-D s herself in the wheel of her chair. NA-D s concerns when we residents up, during	r on 2/2/21, at 1:49 p.m. NA)-D stated R1 required two elt, had a motorized ff did most of the cares for 1 got yeast infections under groin area and had fold area ey applied a cream that she D stated R1 was very stated they toileted R1 every would call when she needed ated sometimes, she could D stated we would change her eded to be changed. NA-D ositioned every two hours and repositioned when she would tode. NA-D stated after she e a while, she would get into R1 preferred to be in her stated R1 could repositioned lchair and changed positions stated staff monitor for skin do cares, washing up g peri-cares and toileting. we give them a bath the nurse				
	completed a skin cl	heck. NA-D stated she would right away any changes in skin				

STATEMEN	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00124	B. WING	B. WING		03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GREEN L	LEA SENIOR LIVING		TH LYNDALE MN 55954	, RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 14	2 830			
	licensed practical n very pleasant lady, not like to lay down incontinent. LPN-C right, she was on La she came, she brou- wear in her underw through these. LPN wheelchair and she reposition. LPN-C stay R1 started to g repositioning. LPN- her needs known. L R1 out of the facility her home and gave brought her back, I open areas. LPN-C with [FM-A] that day the skin assessmer LPN-C stated the a and I recall reportin were not there." LP the family had any of after that outing wh reported the skin co stated on bath days assessment on a w During an interview licensed practical n	on 2/2/21, at 12:09 p.m. urse (LPN)-C stated R1 was a she was in a wheelchair, did in bed and she was stated if she remembered asix, was incontinent when ught in pads from home to ear and she would soak -C stated had R1 motorized would tilt herself back, to stated towards the end of her o into her bed more for C stated R1 was able to make .PN-C stated family had taken <i>i</i> for an appointment, they took ther a bath, and when they understand they reported the stated her before going out <i>j</i> LPN-C said she had done at and her skin was intact. reas were like little, tiny slits g to the DON, "I swear those N-C stated she did not know concerns about her cares until en family gave R1 a bath and oncerns to the facility. LPN-C is nurses completed skin eekly basis. on 2/3/21, at 9:14 a.m. urse (LPN)-B stated when a concern was identified she				
	had the director of r she started a wound documentation. LPI the area, measured	nursing (DON) look at it and d sheet for daily wound N-B stated the DON looked at l it provided any input on how				
	the floor staff docur	ed the provider. LPN-B stated nented on the wound sheet pleted weekly wound				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00124		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
				02/	02/03/2021
ROVIDER OR SUPPLIER					
EA SENIOR LIVING			, RR 2 BOX 49		
SUMMARY STATEMENT OF DEFICIENCIES					(X5)
		PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
Continued From pa	ige 15	2 830			
family are notified. I look at the wound of documentation and on bath day. At 9:20 became aware of F took R1 out of the f LPN-B stated the D repositioning and k we passed along th importance of reposition going to the bathroot was what we were here as her goal was stated she was rep- hours. The DON stated typ the as her goal was stated she was rep- hours. The DON stated typ the am, pm and du notify the nurse if th that could be a con document skin con- (PCC). The DON si call from FM-A that concerns in PCC [F medical record]. Th a skin assessment areas that were of of there were four are abdominal folds that areas on each butto	LPN-B stated nurses are to daily to complete daily they look at the full body audit 6 a.m. LPN-B stated the facility At's skin concerns when family facility for an appointment . DON talked to staff about eeping R1 dry. LPN-B stated the family concerns in report the sitioning and toileting. To n 2/2/21, at 2:17 p.m. the (DON) stated at home R1 was one every two hours and that trying to stay consistent with as to return to home. The DON ositioned every two to three ated to an extent R1 could do r own, she could tilt her ad she could adjust herself N stated staff would boost R1 eeded with an assist of two. pically aides observe skin in ring prn cares. The aides ney see anything not normal cern and they would also ditions in point click care tated she received a phone day she documented the skin Point Click Care-electronic the DON stated she completed and took measurements of concern. The DON stated as, one on each side of at were small slits and small ock. The DON stated all areas	и			
	PROVIDER OR SUPPLIER EA SENIOR LIVING SUMMARY STA (EACH DEFICIENCING) Continued From para assessments. LPN family are notified. look at the wound of documentation and on bath day. At 9:22 became aware of F took R1 out of the f LPN-B stated the D repositioning and k we passed along the importance of repo During an interview director of nursing of going to the bathrood was what we were here as her goal was stated she was rep hours. The DON st it (reposition)on here wheelchair back and frequently. The DON in wheelchair as net that could be a cond document skin con (PCC). The DON st call from FM-A that concerns in PCC [F medical record]. The a skin assessment areas on each buttow were identified by F home. The DON st	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00124 00124 PROVIDER OR SUPPLIER STREET AL IS NOR MABEL, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 assessments. LPN-B stated the provider and family are notified. LPN-B stated nurses are to look at the wound daily to complete daily documentation and they look at the full body audit on bath day. At 9:26 a.m. LPN-B stated the facility became aware of R1's skin concerns when family took R1 out of the facility for an appointment . LPN-B stated the DON talked to staff about repositioning and keeping R1 dry. LPN-B stated we passed along the family concerns in report the importance of repositioning and toileting. During an interview on 2/2/21, at 2:17 p.m. the director of nursing (DON) stated at home R1 was going to the bathroom every two hours and that was what we were trying to stay consistent with here as her goal was to return to home. The DON stated she was repositioned every two to three hours. The DON stated to an extent R1 could do it (reposition)on her own, she could aljust herself frequently. The DON stated staff would boost R1 in wheelchair back and she could adjust herself frequently. The DON stated staff would also document skin conditions in point click care (PCC). The DON stated she received a phone call from FM-A that day she documented the skin concerns in PCC [Point Click Care-electronic medical record]. The DON stated she completed a skin assessment and took measurements of areas that were of concern. The DON stated there were four areas, one on each side of abdominal folds that were small slits and small areas on each buttock. The DON stated a	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A. BUILDING; B. WING	TO OF DEFICIENCIES (X1) PROVIDERSUPPLIENCIAL (X2) MULTIPLE CONSTRUCTION OP CORRECTION 00124 B UILDING: B B B OP CORRECTION 00124 B PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EA SENIOR LIVING 115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954 MABEL, MN 55954 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORFICENCY MUST BE PRECEDED BY FULL PREFIX Continued From page 15 2 830 assessments. LPN-B stated the provider and family are notified. LPN-B stated nurses are to look at the wound daily to complete daily documentation and they look at the full body audit on bath day. At 9:26 a.m. LPN-B stated the facility became aware of R1's skin concerns when family took R1 of the facility of an appointment . LPN-B stated the DON talked to staff about repositioning and toileting. During an interview on 2/2/21, at 2:17 p.m. the director of nursing (DON) stated at home R1 was going to the bathroom every two hours and that was what we were trying to stay consistent with here as here goal was to return to home. The DON stated to she could do it (repositionion) fer own, she could the her wheelchair back and she could adjust herself frequenty. The DON stated staff would boost R1 in wheelchair as needed with an assist of two. The DON stated to here cereived a phone call from FN-A that days the documented the skin concerns in PCC [Point Click Care-electron	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 00124

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 02/03/2021		
		00124					
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GREEN LEA SENIOR LIVING 115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL						
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 16	2 830				
	decided to not have any more treatment and they						
		e DON stated family gave her					
		is when they found the open					
		ated she had just taken over					
		complete an investigation to facility missed seeing the open					
		ated when a skin concern was					
		leted weekly wound					
	•	he daily wound documentation					
		the nurse. The DON stated the	•				
		te board in R1's room and					
		of toileting and repositioning					
		DON stated when FM-A found					
		-A requested stoma paste, so or for an order for stoma paste					
		t. The DON stated we used					
		and found it was getting thick					
		eally helping anything. The					
		ggested nystatin powder to dry					
		absolutely no nystatin or					
		I stated FM-A wanted us to get					
		id get it on (start treatment), so baste from our pharmacy so)				
		g it that night. The DON stated					
	the facility only com						
		he skin concerns as she					
		e the day her measurements					
		ompleted on week three. The					
		ould have expected the facility					
		nese areas and stated nothing					
		attention from staff. The DON					
		versation on 11/3/20 with re FM-A was unhappy with					
		ie skin breakdown areas FM-A					
		ncern. The DON stated she					
		on each shift regarding					
	importance of report	sitioning, toileting and keeping					
		from the areas because of the					
		s. The DON stated she did					
	make the staff awa	re that family was not happy					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00124		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00124	B. WING	02/03/2021		
AME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S ⁻	TATE, ZIP CODE		
REEN	LEA SENIOR LIVING	115 NORT MABEL, M		RR 2 BOX 49		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE COMPLE THE APPROPRIATE DATE	
2 830	with this situation. T they did reposition DON stated she way water, so she was and was also on flu did explain to FM-A repositioning and o identified, she was repositioning and w The Skin Managem procedure revised residents will be as changes in skin con screening, daily wit weekly with bath." SUGGESTED MET The director of nurs all residents at risk concerns to assure necessary treatmen pressure related sk and to promote hea skin concerns. The designee, could con delivery of care; to services are impler non pressure related	The DON stated staff indicated and toilet R1 frequently. The as drinking lots of pop and continuously needing to void id pills. The DON stated she as R1 would often refuse nce the skin issues were more accepting of the vould lay down in bed. The Program policy and February 2019 included, "All sessed for skin integrity or nditions upon preadmission h POC (point of care) and THOD OF CORRECTION: sing or designee, could review for non pressure related skin they are receiving the nt/services to prevent non in concerns from developing aling of non pressure related e director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk of	2 830			