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.

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

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:

- 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).

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	C 02/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/2/21 and 2/3/21 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5536006C, with a deficiency cited at F684. The following complaint was found to be UNSUBSTANTIATED: H5536005C, with assiciated deficiencis cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		2/27/21

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

Electronically Signed | 02/26/2021

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F 609	Continued From page 1 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the allegation of abuse was reported to administration and state agency within 2 hours of the allegation of injury of unknown source for 1 of 1 (R2) resident reviewed for abuse. Findings include: R2 progress note dated 12/1/2020 at 9:01 p.m. noted a large bruise noted on right bicep, measured at 10 cm x 6.5 cm and noted skin was very thin.	F 609	F 609 PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and	

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F 609	Continued From page 2 Vulnerable adult report indicated incident occurred on 12/2/20 at 00:00 of physical abuse of unexplained injury with description of injury as bruise to right bicep. Vulnerable report indicated on 12/2/20 at 1:53p.m. was submitted to Minnesota Department of Health (MDH). Description of incident included resident was observed having a bruise 10cm x 6.5cm to outer right bicep and 2cm x 2 cm to inner right bicep by the assigned nurse during routine skin check and that the cause of the bruise is unknown. No alleged perpetrator was identified. R2 admission record included diagnoses of osteoarthritis, atrial fibrillation, biventricular heart failure, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes, chronic gout, muscle weakness, and urinary tract infection. R2 admission Minimum Data Set (MDS) assessment dated 11/22/20, identified severe cognitive impairment no behaviors, extensive assist with activities of daily living, walker, not steady, history of falls, pain. R2 care plan included R2 is often seen self-transferring to commode or bathroom, requires 1 assist with walker and gait belt; R2 has altered cardiovascular status related to atrial fibrillation and heart failure and to observe for bruising/bleeding and to notify medical practitioner of abnormalities; R2 is considered a vulnerable adult related to impaired physical abilities, impaired cognitive status and communication skills and to report any concerns or complaints immediately; R2 has impairment to skin integrity related to impaired mobility, impaired cognition and incontinence and to	F 609	correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 609, Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) Green Lea Senior Living corrected the deficiency by educating the Executive Director and the Director of Nursing on the process for required notification to state agencies on 2/8/21 by the Accura Nurse Specialist. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 2/8/21 on the vulnerable adult policy by the Director of Nursing Services. The Accura Nurse Specialist will audit all incidents that require state notification for timeliness upon occurrence for 4 weeks and then monthly for 2 months to ensure substantial compliance is met. 3. As part of Green Lea Senior Livings commitment to quality assurance, the DNS and/or designee will report identified concerns through the community□'s QA Process.	

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F 609	Continued From page 3	F 609		

observe, document, and report any skin injuries. It is noted that R2 daughter reported R2 has thin fragile skin and easily gets skin tears and bruises.

During an interview on 2/2/21 at 1:35 p.m., licensed practical nurse (LPN)-A stated the aide was assisting resident to bed and reported a bruise on the upper right arm. LPN-A stated she assessed and measured the bruise. LPN-A stated R2 had behaviors of complaining about black males taking care of her even if they had not been caring for her or say the staff was hurting her even if they were not touching her. LPN-A stated R2 did not prefer the black male staff to care for her. LPN-A stated she did not think the bruise occurred due to abuse. LPN-A stated she is aware of vulnerable adult reporting and the timeframe and has been educated on abuse and reporting. LPN-A stated it would be an error on her part if she did not report it to the DON and physician at the time.

During an interview on 2/2/21 at 2:01 p.m., LPN-C stated any change of condition including skin should be reported immediately to director of nursing and physician and documented on. LPN-C stated if a bruise is found, they are to ask resident how it happened and if the resident is unable to say then it is of unknown origin and reported immediately. LPN-C stated the director of nursing is to be called after hours and on weekends if not at facility. LPN-C stated weekly body audits are done on all residents and documented.

During an interview on 2/2/21 at 2:41p.m., nurse aide (NA)-A stated she noticed the bruise on R2 right upper arm and reported to nurse right away. NA-A stated it was a large solid bruise. NA-A

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F 609	Continued From page 4	F 609		

stated R2 stated she was grabbed when being transferred but could not state who it was.

During an interview on 2/2/21 at 3:31 p.m., director of nursing (DON) stated she was notified of the bruise the morning of 12/2/20 and began the investigation. DON stated the nurse should have called her at time of the finding the night before. DON stated the procedure is to notify her no matter what time. DON stated the vulnerable adult report was filed because the bruise occurred and was unknown for sure of the origin. DON confirmed the vulnerable adult report was reported late and should have been done within 2 hours.

Facility Vulnerable Adult Policy included to ensure the resident is free from abuse, neglect, mistreatment, misappropriation of resident property and exploitation and includes injuries of unknown source sustained that is not reasonably explained immediately. It indicated the facility will report any maltreatment of a vulnerable adult. The procedure included mandated reporters employed by facility shall report immediately. The policy definition of injury of unknown source included the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the intent of the injury or the location of the injury. Internal reporting procedure included that during the shift the alleged abuse or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their supervisor after securing the residents safety and following the review of the situation, the supervisor will immediately report to the administrator and director of nursing. It included upon report to a

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F 609	Continued From page 5 supervisor of the suspected abuse, the employee in question will be interviewed, reassigned duties, placed under direct supervision, assigned to non-resident related tasks or suspended pending investigation as protection of the resident. It included the administrator or director of nursing shall determine if the incident/allegation meets the criteria for reportable incident which will be reported immediately but no later than 2 hours after forming the suspicion. It indicated the supervisor, director of nursing, or administrator will immediately institute an internal investigation of the reported allegation or incident which may include interviews of staff, resident interviews, witness interviews, environmental review, resident health issues, behavior review, and medication review.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		2/27/21

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F 610	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the allegation of abuse was thoroughly investigated for an injury of unknown source for 1 of 1 (R2) resident reviewed for abuse. Findings include: R2 progress note dated 12/1/2020 at 9:01 p.m. noted a large bruise noted on right bicep, measured at 10 cm x 6.5 cm and noted skin was very thin. R2 admission Minimum Data Set (MDS) assessment dated 11/22/20, identified severe cognitive impairment no behaviors, requires extensive assist with activities of daily living, walker, not steady, history of falls, pain. R2 care plan included R2 is often seen self-transferring to commode or bathroom, requires 1 assist with walker and gait belt; ; R2 has potential altered communication problem with difficulty finding words to finish thoughts and misses parts or intent of incoming messages due to cognitive loss; R2 has altered cardiovascular status related to atrial fibrillation and heart failure and to observe for bruising/bleeding and to notify medical practitioner of abnormalities; R2 is considered a vulnerable adult related to impaired physical abilities, impaired cognitive status and communication skills and to report any concerns or complaints immediately; R2 has impairment to skin integrity related to impaired mobility, impaired cognition and incontinence and to observe, document, and report any skin injuries. It is noted that R2 daughter reported R2 has thin	F 610	F 610 PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 610 Investigate/Prevent/Correct Alleged Violations CFR(s): 483.12(c)(2)-(4) Green Lea Senior Living corrected the deficiency by educating the Executive Director and the Director of Nursing on the process for thoroughly investigating and submitting investigations within 5 working days of the alleged violation on 2/8/21 by the Accura Nurse Specialist. 2. To correct the deficiency and to ensure the problem does not recur the Accura Nurse Specialist will audit all incidents that require state notification upon occurrence	

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F 610	Continued From page 7 fragile skin and easily gets skin tears and bruises. During an interview on 2/2/21 at 1:35 p.m., licensed practical nurse (LPN)-A stated the aide was assisting resident to bed and noticed a bruise to the upper right arm. LPN-A stated she assessed and measured the bruise. LPN-A stated R2 had behaviors of complaining about black males taking care of her even if they had not been caring for her or say the staff were hurting her even if not touching her. LPN-A stated she questioned the staff working and staff denied knowing how the bruise got there. LPN-A stated she believed it was the blood pressure cuff as it pumped so tight and many of the residents complained. LPN-A stated the bruise was consistent where the blood pressure goes and the size of the cuff. LPN-A stated the director of nursing and family was notified the next day as this occurred in the evening and because she did not think it was abuse. LPN-A stated the family had stated R2 had a history of bruising easily. LPN-A stated staff were told not to take blood pressure on that arm. LPN-A stated she was not concerned of any abuse. During an interview on 2/2/21 at 2:41p.m., nurse aide (NA)-A stated she noticed the bruise on R2 right upper reported to nurse right away. NA-A stated it was a large solid bruise. NA-A stated R2 stated she was grabbed when being transferred but could not state who it was. During an interview on 2/2/21 at 3:31 p.m., director of nursing (DON) stated she was notified of the bruise the morning of 12/2/20 and began the investigation. DON stated the nurse should have called her at time of the finding the night before. DON stated the procedure is to notify her	F 610	for accuracy of investigation for 4 weeks and then monthly for 2 months to ensure substantial compliance is met. 3. As part of Green Lea Senior Livings commitment to quality assurance, the DNS and/or designee will report identified concerns through the community□s quality Assurance process.	

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F 610	Continued From page 8	F 610		

no matter what time. DON stated it was a large solid bruise that resembled the size and location of the blood pressure cuff. DON stated R2 denied anyone hurting her or being rough with her. DON stated no alleged perpetrator was identified. DON stated staff were interviewed regarding whether the staff had worked with R2, how R2 transferred, and if bruising was observed. DON stated other residents were not interviewed. DON stated the process would be to interview other residents also. DON stated she did verbal education with staff on proper handling and transferring but did not document the education with staff signatures. DON stated the vulnerable adult report was filed because the bruise occurred and was unknown for sure of the origin. DON stated R2 was cognitively impaired.

During a follow up interview on 2/3/21at 12:02 p.m., DON confirmed only staff interviews were completed and they did not interview other residents. DON stated the physician was not notified of the bruise. DON stated the physician should have been notified regarding the bruise and they are to notify the physician of any skin changes. DON stated the nurse working at time of discovery of the skin change or bruise is responsible for notifying the physician.

Vulnerable adult report indicated incident occurred on 12/2/20 at 00:00. Of allegation of physical abuse of unexplained injury with description of injury as bruise to right bicep. Vulnerable report indicated 12/2/20 at 13:53 as date and time submitted to Minnesota Department of Health (MDH). Description of incident included resident was observed having a bruise 10cm x 6.5cm to outer right bicep and 2cm x 2 cm to inner right bicep by the assigned nurse

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during routine skin check and that the cause of the bruise is unknown. No alleged perpetrator was identified. The facility 5 day investigation report submitted to the State Agency dated 12/7/20 at 4:02 p.m. included, interviews of staff regarding the bruise on R2, R2 care plan for skin issues that notes bruises easily, and R2 progress notes at time of incident. Facility investigation documents did not include interviews of staff on duty during the time of incident, interviews of staff regarding possible abuse, interviews of other residents, documentation of R2 interview, or notification to the physician. In addition, the facility failed to provide education on vulnerable adult reporting and abuse including injury of unknown sources.

Facility Vulnerable Adult Policy included to ensure the resident is free from abuse, neglect, mistreatment, misappropriation of resident property and exploitation and includes injuries of unknown source sustained that is not reasonably explained immediately. It indicated the facility will report any maltreatment of a vulnerable adult. The procedure included mandated reporters employed by facility shall report immediately. The policy definition of injury of unknown source included the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the intent of the injury or the location of the injury. Internal reporting procedure included that during the shift the alleged abuse or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their supervisor after securing the residents safety and following the review of the situation, the supervisor will immediately report to the administrator and

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F 610	Continued From page 10 director of nursing. It included upon report to a supervisor of the suspected abuse, the employee in question will be interviewed, reassigned duties, placed under direct supervision, assigned to non-resident related tasks or suspended pending investigation as protection of the resident. It included the administrator or director of nursing shall determine if the incident/allegation meets the criteria for reportable incident which will be reported immediately but no later than 2 hours after forming the suspicion. It indicated the supervisor, director of nursing, or administrator will immediately institute an internal investigation of the reported allegation or incident which may include interviews of staff, resident interviews, witness interviews, environmental review, resident health issues, behavior review, and medication review. Facility Change in Condition policy included the guideline to initiate change in condition using the situation, background, assessment, recommendation (SBAR) tool to inform the physician.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		2/27/21

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F 684	Continued From page 11 Based on interview and document review, the facility failed to identify non-pressure related skin conditions for 1 of 3 residents (R1) reviewed for non-pressure related skin conditions. Findings include: R1's Admission Record indicated R1 was admitted to the facility on 9/20/20 with diagnoses of heart failure, drug induced Parkinsonism, mixed incontinence and bipolar disorder. R1's admission minimum data set (MDS) assessment, dated 9/26/20 identified R1 as having moderately impaired cognition and requiring extensive assistance of two staff with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further identified R1 as being frequently incontinent of bladder, always continent of bowel and had no toileting program. R1 was at risk for developing pressure ulcers and had no pressure ulcers or moisture associated skin damage. R1 had a pressure reducing device for the chair and bed. R1's care plan initiated 9/21/20, identified R1 had potential impairment to skin integrity r/t (related to) incontinence, impaired mobility, and obesity. A goal was identified for R1 to be free from skin alteration/injury through the review period. Interventions included: Attempt to reposition off area and/or not position on area when possible dated 11/18/20, Educate, cue, and assist with repositioning and off loading dated 11/18/2020 and Pain management. R1's body audit progress note dated 9/20/20 included, "Body audit completed. Fingernails are clean and trimmed. Toenails are cleaned and	F 684	F 684 PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 684, Quality of Care CFR(s): 483.25 Green Lea Senior Living corrected the deficiency by completing the comprehensive skin and position assessment on all residents to assess for potential risk of skin alterations and care plans were updated with appropriate interventions on 2/23/21. 2. To correct the deficiency and to ensure the problem does not recur the DNS educated the nursing staff on the skin/wound process on 2/8/21. The DNS and/or designee will audit 2 body audit assessments and PCC documentation for accuracy daily Monday thru Friday for 4	

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F 684	Continued From page 12 trimmed at this time. Inspection of feet, ankles and toes indicate they are clear. Inspection of heels indicate they are firm. Edema present. Skin is very intact. No powders to folds, please use VIVA towels and creams." During an interview on 2/1/21, at 2:51 p.m. family member (FM)-A stated we had a specific lotion and a water barrier cream, lantiseptic that we purchased and supplied to the facility that we want applied to [R1] daily underneath her folds, under her breasts, peri area and butt to prevent skin break down. It was a daily care skin protectant cream. FM-A stated she told them not to use any kind of powder on her, because it breaks downs her skin. FM-A stated when she started to get skin breakdown on her butt, they (the facility) went ahead and got a stoma adhesive paste to use on her butt. R1 called me and told me her but hurt and I mentioned it to the nurse. I told the nurse that sometimes when she had breakdown on her butt they would use a stoma adhesive mixture and the facility went ahead and ordered the straight up stoma adhesive paste from their pharmacy, which I had told them not to do. I had told them to order all prescription from [R1's] pharmacy and FM-A will bring it to them. FM-A stated R1 was supposed to have a breast surgery for her cancer, we took her out of the facility to have her pre operation appointment done. FM-A stated R1 started to cry and stated she did not want to have the surgery because she did not want to have to go back to the nursing home. FM-A stated R1 stated I see how they live; I do not want to have the surgery. FM-A stated R1 did not go to the appointment, we brought her home and gave her a good shower and we saw these sores underneath her breast, underneath her folds in the peri area and her butt	F 684	weeks and then randomly to maintain substantial compliance. 3. As part of Green Lea Senior Livings commitment to quality assurance, the DNS and/or designee will report identified concerns through the community□s QA Process.	

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look like hamburger. FM-A stated R1 passed away on 1/28/21. FM-A stated even if my mom would have wanted to have the surgery, they would have told us she could not have it because of the risk of infections from her sores. FM-A stated by the time we got the sores healed it was too late because the breast cancer had spread. FM-A stated R1 had three very deep wounds, and FM-A was able to heal them by around the 5th of January. FM-A stated R1's, "bottom was hamburger, literally hamburger." FM-A stated She had a special wheelchair chair that had gadgets to prevent breakdown, had special instructions, reclined tilted, it did everything to prevent breakdown. FM-A stated twice I went there (to the facility) and her pants legs were soaked, she was sitting there in her chair and she was soaking wet. FM-A stated they called me and told me she was on her light a lot to have to go to the bathroom. FM-A stated the facility did not share that R1 was uncooperative with cares other than having to go to the bathroom all the time.

R1's nurse progress note dated 11/3/20 included, "This nurse received a phone call on 11/3/20 from [family member-A]. [R1] had gone out for an appointment on 11/2/20. . [FM-A] was transporting her to appointment. [FM-A] then took [R1] to her home and gave her a bath and made her dinner and [FM-B] came over to talk ...Also during this conversation [FM-A] wanted to review [R1's] skin care regimen. This was reviewed and notes were typed up for nurses and aides to review, there is an information sheet in [R1's] room as well. She does have some moisture associated areas. This nurse asked if we possibly try to get an order for some Nystatin powder to help dry up the high moisture areas in her folds. [FM-A] states that she does not want

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any powders used as she has used them in the past and they did not work. [FM-A] wants staff to continue using the cream that she has supplied as this is what she was using at home prior to admission and will be using when she discharges home."

According to R1's medical record there was no identification of wounds prior to the family member bringing the skin concerns to their attention on 11/3/20. Although the following 4 skin integrity evaluations were completed after FM-A phone call, they do not identify where the wounds were located.

R1's Weekly Skin Integrity Evaluation Note dated 11/3/20, at 4:05 p.m. included, "Late Entry: Note Text: MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 2cm x1cm, No undermining. No tunneling is present. Tissue type: Bright Pink or Red, % of each tissue type: left blank. Drainage Amount: None, Wound edge: Distint [sic] and Attached Peri-wound: Normal Infection present: No Mild pain present during treatment. Current treatment: Stoma paste per [FM-A's] request as used before at home and viva papertowels [sic]. Treatment Effective: Yes. Status of wound is active. 13.0 Moderate Risk, 5.0 PUSH SCORE. Identified on 11/3/2020, per daughter [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

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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 4:12 p.m. included, "Late Entry: Note Text: MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence, 0.6cm x 0.5cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red % of each tissue type: Left blank. Drainage Amount: None Wound edge: Distint [sic] and Attached Peri-wound: Normal Infection present: No Mild pain present during treatment. Current treatment: Stoma paste per [FM-A's] request as used before at home and viva papertowels [sic]. Treatment Effective: Yes Status of wound is active. 13.0 Moderate Risk, 5.0 PUSH SCORE. Identified on 11/3/2020, per daughter [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]

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needs to go again."

R1's Weekly Skin Integrity Evaluation Note dated 11/3/2020, at 4:15 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]. 3cm x 0.2cm, No undermining. No tunneling is present. Tissue type: Bright Beefy Red. % of each tissue type: Left blank. Drainage Amount: Scant Serous. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: 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

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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: Bright Beefy Red. % of each tissue type: Left blank. Drainage Amount: Scant Serous. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: stoma paste and viva paper towel as request by [FM-A], as this is what they did at hoe [sic] 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's] 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 progress noted date 11/4/20 included, " ...TX [treatment] with cream applied to abdominal, breast and buttocks (family provides.), with viva paper towel for wicking. Family requests no powders, corn starch or nystatin be used for these problem areas."

R1's body audit progress note dated 11/6/20

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included, "Body audit completed. Fingernails are clean and trimmed. Toenails are cleaned and trimmed at this time. Inspection of feet, ankles and toes indicate they are clear. Inspection of heels indicate they are firm. Edema present. Breast folds improved slight pink beneath, no open areas, abdominal folds lower front area with small opening scant amount serosanguineous. Right side abdominal fold small open area with scant serosanguineous drainage. Abdominal folds improving. Buttock maceration/sheering noted bilateral, scant serous drainage present.

R1's Skin/Wound Note dated 11/8/20 included, "A little pink under bilat [sic] breasts. No open areas. -Anterior abdominal fold and right abdominal fold each have small open area. -Bilateral buttock maceration/sheering 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."

R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:26 p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 0.75 x 0.5cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red. % of each tissue type: Left blank. Drainage Amount: None Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: Laniseptic and telfa non stick drsg

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[dressing]. Treatment Effective: Yes Status of wound is active.14.0 Moderate Risk. 3.0 PUSH SCORE. Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [register nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking, area is healing and measurements have improved."

R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:33p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 3cm x 1cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red % of each tissue type: Left blank. Drainage Amount: None. Wound edge: Distint [sic] and Attached. Peri-wound: Normal Infection present: No. Mild pain present during treatment. Current treatment: lanispetic cream and telfa drsg [dressing]. Treatment Effective: Yes. Status of wound is active.14.0 Moderate Risk. 6.0 PUSH SCORE. Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [registered nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking. area is slightly larger in measurements."

R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:43p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. No undermining. No tunneling is

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present. Tissue type: Bright Pink or Red % of each tissue type: Left blank. Drainage Amount: None. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: Stoma paste per [FM-A's] request as used before at home and viva papertowels [sic]. Treatment Effective: Yes. Status of wound is active.13.0 Moderate Risk. 5.0 PUSH SCORE. Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [register nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking. Area is slightly larger in measurements."

R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:45p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 0.6cm x 0.5cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red. % of each tissue type: Left blank. Drainage Amount: None. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: treatment changed to laniseptic and telfa. Treatment Effective: Yes Status of wound is active.13.0 Moderate Risk. 3.0 PUSH SCORE Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [register nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking. area is slightly larger in

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	245536	A. BUILDING _____ B. WING _____	C 02/03/2021

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

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

R1's progress note dated 11/12/20 included, "RECAPITULATION OF STAY: [R1] a 80 year old female came to the facility due to the daughters need for back surgery. She is very pleasant and able to make her needs known. Her pain varies and uses both scheduled and as needed pain medications. Currently the only skin issue is on the buttocks. The abdominal fold is currently closed. Pink in color. She continues with oxygen and will be going home with her own medications."

R1's body audit progress note dated 11/13/20 included, "Body audit completed. Fingernails are clean and trimmed. Toenails are cleaned and trimmed at this time. Inspection of feet, ankles and toes indicate they are clear. Inspection of heels indicate they are firm. Edema present. Abdomen folds are not open and pink in color. Underneath the breasts are intact color darker shade purple"

R1's progress note dated 11/16/20 included, [R1] has left the facility with her [Family members] to go home. She was in her electric wheelchair. Using the facilities portable oxygen tank. She transferred to the front passengers [sic] seat with the assistance of her [family member]."

During an interview on 2/2/21, at 1:49 p.m. nursing assistant (NA)-D stated R1 required two assist with a gait belt, had a motorized wheelchair, and staff did most of the cares for her. NA-D stated R1 got yeast infections under her breasts, in the groin area and had fold area concerns where they applied a cream that she

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used at home. NA-D stated R1 was very incontinent. NA-D stated they toileted R1 every two hours, and she would call when she needed to go to toilet but stated sometimes, she could just not hold it. NA-D stated we would change her as often as she needed to be changed. NA-D stated R1 was repositioned every two hours and she would also get repositioned when she would get up to the commode. NA-D stated after she had been here quite a while, she would get into bed. NA-D stated R1 preferred to be in her wheelchair. NA-D stated R1 could repositioned herself in the wheelchair and changed positions of her chair. NA-D stated staff monitor for skin concerns when we do cares, washing up residents up, during peri-cares and toileting. NA-D stated when we give them a bath the nurse completed a skin check. NA-D stated she would report to the nurse right away any changes in skin and have the nurse come to look at it.

During an interview on 2/2/21, at 12:09 p.m. licensed practical nurse (LPN)-C stated R1 was a very pleasant lady, she was in a wheelchair, did not like to lay down in bed and she was incontinent. LPN-C stated if she remembered right, she was on Lasix, was incontinent when she came, she brought in pads from home to wear in her underwear and she would soak through these. LPN-C stated had R1 motorized wheelchair and she would tilt herself back, to reposition. LPN-C stated towards the end of her stay R1 started to go into her bed more for repositioning. LPN-C stated R1 was able to make her needs known. LPN-C stated family had taken R1 out of the facility for an appointment, they took her home and gave her a bath, and when they brought her back, I understand they reported the open areas. LPN-C stated her before going out

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with [FM-A] that day LPN-C said she had done the skin assessment and her skin was intact. LPN-C stated the areas were like little, tiny slits and I recall reporting to the DON, "I swear those were not there." LPN-C stated she did not know the family had any concerns about her cares until after that outing when family gave R1 a bath and reported the skin concerns to the facility. LPN-C stated on bath days nurses completed skin assessment on a weekly basis.

During an interview on 2/3/21, at 9:14 a.m. licensed practical nurse (LPN)-B stated when a new wound or skin concern was identified she had the director of nursing (DON) look at it and she started a wound sheet for daily wound documentation. LPN-B stated the DON looked at the area, measured it provided any input on how to treat it and notified the provider. LPN-B stated the floor staff documented on the wound sheet daily and DON completed weekly wound 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

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hours. The DON stated to an extent R1 could do it (reposition)on her own, she could tilt her wheelchair back and she could adjust herself frequently. The DON stated staff would boost R1 in wheelchair as needed with an assist of two. The DON stated typically aides observe skin in the am, pm and during prn cares. The aides notify the nurse if they see anything not normal that could be a concern and they 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 all areas were identified by FM-A the day family took her home. The DON stated family had her out of the building for an oncology appointment and R1 decided to not have any more treatment and they took her home. The DON stated family gave her a spa day and that is when they found the open areas. The DON stated she had just taken over as a DON and did complete an investigation to figure out how the facility missed seeing the open areas. The DON stated when a skin concern was identified she completed weekly wound assessments and the daily wound documentation was completed by the nurse. The DON stated the facility put up a white board in R1's room and documented times of toileting and repositioning on the board. The DON stated when FM-A found the open areas FM-A requested stoma paste, so we asked the doctor for an order for stoma paste per FM-A's request. The DON stated we used that for a few days and found it was getting thick

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and tacky and not really helping anything. The DON stated we suggested nystatin powder to dry it up and FM-A said absolutely no nystatin or powders. The DON stated FM-A wanted us to get the stoma paste and get it on (start treatment), so we got the Stoma paste from our pharmacy so we could start using it that night. The DON stated the facility only completed two weekly measurements of the skin concerns as she discharged to home the day her measurements would have been completed on week three. The DON stated she would have expected the facility to have identified these areas and stated nothing was brought to her attention from staff. The DON stated after the conversation on 11/3/20 with FM-A she was aware FM-A was unhappy with cares and stated the skin breakdown areas FM-A found was a big concern. The DON stated she talked with nurses on each shift regarding importance of repositioning, toileting and keeping the moisture away from the areas because of the identified skin areas. The DON stated she did make the staff aware that family was not happy with this situation. The DON stated staff indicated they did reposition and toilet R1 frequently. The DON stated she was drinking lots of pop and water, so she was continuously needing to void and was also on fluid pills. The DON stated she did explain to FM-A R1 would often refuse repositioning and once the skin issues were identified, she was more accepting of the repositioning and would lay down in bed.

The Skin Management Program policy and procedure revised February 2019 included, "All residents will be assessed for skin integrity or changes in skin conditions upon preadmission screening, daily with POC (point of care) and weekly with bath."

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DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00124	A. BUILDING: _____ B. WING _____	C 02/03/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/2/21 and 2/3/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5536006C with a licensing order issued at S4658.0520 Subp.1. The following complaint was found to be UNSUBSTANTIATED: H5536005C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify non-pressure related skin conditions for 1 of 3 residents (R1) reviewed for non-pressure related skin conditions. Findings include: R1's Admission Record indicated R1 was admitted to the facility on 9/20/20 with diagnoses	2 830	S 2830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 1. Corrected.	2/27/21

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2 830	Continued From page 3 of heart failure, drug induced Parkinsonism, mixed incontinence and bipolar disorder. R1's admission minimum data set (MDS) assessment, dated 9/26/20 identified R1 as having moderately impaired cognition and requiring extensive assistance of two staff with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further identified R1 as being frequently incontinent of bladder, always continent of bowel and had no toileting program. R1 was at risk for developing pressure ulcers and had no pressure ulcers or moisture associated skin damage. R1 had a pressure reducing device for the chair and bed. R1's care plan initiated 9/21/20, identified R1 had potential impairment to skin integrity r/t (related to) incontinence, impaired mobility, and obesity. A goal was identified for R1 to be free from skin alteration/injury through the review period. Interventions included: Attempt to reposition off area and/or not position on area when possible dated 11/18/20, Educate, cue, and assist with repositioning and off loading dated 11/18/2020 and Pain management. R1's body audit progress note dated 9/20/20 included, "Body audit completed. Fingernails are clean and trimmed. Toenails are cleaned and trimmed at this time. Inspection of feet, ankles and toes indicate they are clear. Inspection of heels indicate they are firm. Edema present. Skin is very intact. No powders to folds, please use VIVA towels and creams." During an interview on 2/1/21, at 2:51 p.m. family member (FM)-A stated we had a specific lotion and a water barrier cream, lantiseptic that we purchased and supplied to the facility that we	2 830		

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2 830	Continued From page 4	2 830		

want applied to [R1] daily underneath her folds, under her breasts, peri area and butt to prevent skin break down. It was a daily care skin protectant cream. FM-A stated she told them not to use any kind of powder on her, because it breaks downs her skin. FM-A stated when she started to get skin breakdown on her butt, they (the facility) went ahead and got a stoma adhesive paste to use on her butt. R1 called me and told me her but hurt and I mentioned it to the nurse. I told the nurse that sometimes when she had breakdown on her butt they would use a stoma adhesive mixture and the facility went ahead and ordered the straight up stoma adhesive paste from their pharmacy, which I had told them not to do. I had told them to order all prescription from [R1's] pharmacy and FM-A will bring it to them. FM-A stated R1 was supposed to have a breast surgery for her cancer, we took her out of the facility to have her pre operation appointment done. FM-A stated R1 started to cry and stated she did not want to have the surgery because she did not want to have to go back to the nursing home. FM-A stated R1 stated I see how they live; I do not want to have the surgery. FM-A stated R1 did not go to the appointment, we brought her home and gave her a good shower and we saw these sores underneath her breast, underneath her folds in the peri area and her butt look like hamburger. FM-A stated R1 passed away on 1/28/21. FM-A stated even if my mom would have wanted to have the surgery, they would have told us she could not have it because of the risk of infections from her sores. FM-A stated by the time we got the sores healed it was too late because the breast cancer had spread. FM-A stated R1 had three very deep wounds, and FM-A was able to heal them by around the 5th of January. FM-A stated R1's, "bottom was hamburger, literally hamburger." FM-A stated She

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

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2 830	Continued From page 5	2 830		

had a special wheelchair chair that had gadgets to prevent breakdown, had special instructions, reclined tilted, it did everything to prevent breakdown. FM-A stated twice I went there (to the facility) and her pants legs were soaked, she was sitting there in her chair and she was soaking wet. FM-A stated they called me and told me she was on her light a lot to have to go to the bathroom. FM-A stated the facility did not share that R1 was uncooperative with cares other than having to go to the bathroom all the time.

R1's nurse progress note dated 11/3/20 included, "This nurse received a phone call on 11/3/20 from [family member-A]. [R1] had gone out for an appointment on 11/2/20. . [FM-A] was transporting her to appointment. [FM-A] then took [R1] to her home and gave her a bath and made her dinner and [FM-B] came over to talk ...Also during this conversation [FM-A] wanted to review [R1's] skin care regimen. This was reviewed and notes were typed up for nurses and aides to review, there is an information sheet in [R1's] room as well. She does have some moisture associated areas. This nurse asked if we possibly try to get an order for some Nystatin powder to help dry up the high moisture areas in her folds. [FM-A] states that she does not want any powders used as she has used them in the past and they did not work. [FM-A] wants staff to continue using the cream that she has supplied as this is what she was using at home prior to admission and will be using when she discharges home."

According to R1's medical record there was no identification of wounds prior to the family member bringing the skin concerns to their attention on 11/3/20. Although the following 4 skin integrity evaluations were completed after

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2 830	Continued From page 6 FM-A phone call, they do not identify where the wounds were located. R1's Weekly Skin Integrity Evaluation Note dated 11/3/20, at 4:05 p.m. included, "Late Entry: Note Text: MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 2cm x1cm, No undermining. No tunneling is present. Tissue type: Bright Pink or Red, % of each tissue type: left blank. Drainage Amount: None, Wound edge: Distint [sic] and Attached Peri-wound: Normal Infection present: No Mild pain present during treatment. Current treatment: Stoma paste per [FM-A's] request as used before at home and viva papertowels [sic]. Treatment Effective: Yes. Status of wound is active. 13.0 Moderate Risk, 5.0 PUSH SCORE. Identified on 11/3/2020, per daughter [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 4:12 p.m. included, "Late Entry: Note Text: MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence,	2 830		

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2 830	Continued From page 7 0.6cm x 0.5cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red % of each tissue type: Left blank. Drainage Amount: None Wound edge: Distint [sic] and Attached Peri-wound: Normal Infection present: No Mild pain present during treatment. Current treatment: Stoma paste per [FM-A's] request as used before at home and viva papertowels [sic]. Treatment Effective: Yes Status of wound is active. 13.0 Moderate Risk, 5.0 PUSH SCORE. Identified on 11/3/2020, per daughter [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 4:15 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]. 3cm x 0.2cm, No undermining. No tunneling is present. Tissue type: Bright Beefy Red. % of each tissue type: Left blank. Drainage Amount: Scant Serous. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment:	2 830		

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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: Bright Beefy Red. % of each tissue type: Left blank. Drainage Amount: Scant Serous. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: stoma paste and viva paper towel as request by [FM-A], as this is what they did at hoe [sic] 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's] request, when this has happened before they would use

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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 progress noted date 11/4/20 included, " ...TX [treatment] with cream applied to abdominal, breast and buttocks (family provides.), with viva paper towel for wicking. Family requests no powders, corn starch or nystatin be used for these problem areas."

R1's body audit progress note dated 11/6/20 included, "Body audit completed. Fingernails are clean and trimmed. Toenails are cleaned and trimmed at this time. Inspection of feet, ankles and toes indicate they are clear. Inspection of heels indicate they are firm. Edema present. Breast folds improved slight pink beneath, no open areas, abdominal folds lower front area with small opening scant amount serosanguineous. Right side abdominal fold small open area with scant serosanguineous drainage. Abdominal folds improving. Buttock maceration/sheering noted bilateral, scant serous drainage present.

R1's Skin/Wound Note dated 11/8/20 included, "A little pink under bilat [sic] breasts. No open areas. -Anterior abdominal fold and right abdominal fold

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2 830	Continued From page 10 each have small open area. -Bilateral buttock maceration/sheering 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." R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:26 p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 0.75 x 0.5cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red. % of each tissue type: Left blank. Drainage Amount: None Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: Laniseptic and telfa non stick drsg [dressing]. Treatment Effective: Yes Status of wound is active.14.0 Moderate Risk. 3.0 PUSH SCORE. Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [register nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking, area is healing and measurements have improved." R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:33p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 3cm x 1cm. No undermining. No tunneling is present. Tissue type: Bright Pink or	2 830		

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2 830	Continued From page 11 Red % of each tissue type: Left blank. Drainage Amount: None. Wound edge: Distint [sic] and Attached. Peri-wound: Normal Infection present: No. Mild pain present during treatment. Current treatment: lanispetic cream and telfa drsg [dressing]. Treatment Effective: Yes. Status of wound is active.14.0 Moderate Risk. 6.0 PUSH SCORE. Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [registered nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking. area is slightly larger in measurements." R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:43p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. No undermining. No tunneling is present. Tissue type: Bright Pink or Red % of each tissue type: Left blank. Drainage Amount: None. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: Stoma paste per [FM-A's] request as used before at home and viva papertowels [sic]. Treatment Effective: Yes. Status of wound is active.13.0 Moderate Risk. 5.0 PUSH SCORE. Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [register nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking. Area is slightly larger in measurements."	2 830		

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R1's Weekly Skin Integrity Evaluation Note dated 11/9/20, at 4:45p.m. included, "MASD [moisture associated skin damage] Type of alteration: MASD [moisture associated skin damage] from incontinence. 0.6cm x 0.5cm. No undermining. No tunneling is present. Tissue type: Bright Pink or Red. % of each tissue type: Left blank. Drainage Amount: None. Wound edge: Distint [sic] and Attached. Peri-wound: Normal. Infection present: No. Mild pain present during treatment. Current treatment: treatment changed to laniseptic and telfa. Treatment Effective: Yes Status of wound is active.13.0 Moderate Risk. 3.0 PUSH SCORE Over the weekend the stoma paste and viva paper towels were creating a thick paste that was difficult and painful when removed form areas. [R1] refused the stoma paste, [register nurse RN-A] spoke with [FM-A] and [FM-A] wasted [sic] the laniseptic cream used, this is being applied and a telfa drsg [dressing] to prevent sticking. area is slightly larger in measurements.

R1's progress note dated 11/12/20 included, "RECAPITULATION OF STAY: [R1] a 80 year old female came to the facility due to the daughters need for back surgery. She is very pleasant and able to make her needs known. Her pain varies and uses both scheduled and as needed pain medications. Currently the only skin issue is on the buttocks. The abdominal fold is currently closed. Pink in color. She continues with oxygen and will be going home with her own medications."

R1's body audit progress note dated 11/13/20 included, "Body audit completed. Fingernails are clean and trimmed. Toenails are cleaned and trimmed at this time. Inspection of feet, ankles and toes indicate they are clear. Inspection of

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2 830	Continued From page 13 heels indicate they are firm. Edema present. Abdomen folds are not open and pink in color. Underneath the breasts are intact color darker shade purple" R1's progress note dated 11/16/20 included, [R1] has left the facility with her [Family members] to go home. She was in her electric wheelchair. Using the facilities portable oxygen tank. She transferred to the front passengers [sic] seat with the assistance of her [family member]." During an interview on 2/2/21, at 1:49 p.m. nursing assistant (NA)-D stated R1 required two assist with a gait belt, had a motorized wheelchair, and staff did most of the cares for her. NA-D stated R1 got yeast infections under her breasts, in the groin area and had fold area concerns where they applied a cream that she used at home. NA-D stated R1 was very incontinent. NA-D stated they toileted R1 every two hours, and she would call when she needed to go to toilet but stated sometimes, she could just not hold it. NA-D stated we would change her as often as she needed to be changed. NA-D stated R1 was repositioned every two hours and she would also get repositioned when she would get up to the commode. NA-D stated after she had been here quite a while, she would get into bed. NA-D stated R1 preferred to be in her wheelchair. NA-D stated R1 could repositioned herself in the wheelchair and changed positions of her chair. NA-D stated staff monitor for skin concerns when we do cares, washing up residents up, during peri-cares and toileting. NA-D stated when we give them a bath the nurse completed a skin check. NA-D stated she would report to the nurse right away any changes in skin and have the nurse come to look at it.	2 830		

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2 830	Continued From page 14 During an interview on 2/2/21, at 12:09 p.m. licensed practical nurse (LPN)-C stated R1 was a very pleasant lady, she was in a wheelchair, did not like to lay down in bed and she was incontinent. LPN-C stated if she remembered right, she was on Lasix, was incontinent when she came, she brought in pads from home to wear in her underwear and she would soak through these. LPN-C stated had R1 motorized wheelchair and she would tilt herself back, to reposition. LPN-C stated towards the end of her stay R1 started to go into her bed more for repositioning. LPN-C stated R1 was able to make her needs known. LPN-C stated family had taken R1 out of the facility for an appointment, they took her home and gave her a bath, and when they brought her back, I understand they reported the open areas. LPN-C stated her before going out with [FM-A] that day LPN-C said she had done the skin assessment and her skin was intact. LPN-C stated the areas were like little, tiny slits and I recall reporting to the DON, "I swear those were not there." LPN-C stated she did not know the family had any concerns about her cares until after that outing when family gave R1 a bath and reported the skin concerns to the facility. LPN-C stated on bath days nurses completed skin assessment on a weekly basis. During an interview on 2/3/21, at 9:14 a.m. licensed practical nurse (LPN)-B stated when a new wound or skin concern was identified she had the director of nursing (DON) look at it and she started a wound sheet for daily wound documentation. LPN-B stated the DON looked at the area, measured it provided any input on how to treat it and notified the provider. LPN-B stated the floor staff documented on the wound sheet daily and DON completed weekly wound	2 830		

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

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2 830	Continued From page 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 tilt her wheelchair back and she could adjust herself frequently. The DON stated staff would boost R1 in wheelchair as needed with an assist of two. The DON stated typically aides observe skin in the am, pm and during prn cares. The aides notify the nurse if they see anything not normal that could be a concern and they 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 all areas were identified by FM-A the day family took her home. The DON stated family had her out of the building for an oncology appointment and R1	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00124	A. BUILDING: _____ B. WING _____	C 02/03/2021

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2 830	Continued From page 16	2 830		

decided to not have any more treatment and they took her home. The DON stated family gave her a spa day and that is when they found the open areas. The DON stated she had just taken over as a DON and did complete an investigation to figure out how the facility missed seeing the open areas. The DON stated when a skin concern was identified she completed weekly wound assessments and the daily wound documentation was completed by the nurse. The DON stated the facility put up a white board in R1's room and documented times of toileting and repositioning on the board. The DON stated when FM-A found the open areas FM-A requested stoma paste, so we asked the doctor for an order for stoma paste per FM-A's request. The DON stated we used that for a few days and found it was getting thick and tacky and not really helping anything. The DON stated we suggested nystatin powder to dry it up and FM-A said absolutely no nystatin or powders. The DON stated FM-A wanted us to get the stoma paste and get it on (start treatment), so we got the Stoma paste from our pharmacy so we could start using it that night. The DON stated the facility only completed two weekly measurements of the skin concerns as she discharged to home the day her measurements would have been completed on week three. The DON stated she would have expected the facility to have identified these areas and stated nothing was brought to her attention from staff. The DON stated after the conversation on 11/3/20 with FM-A she was aware FM-A was unhappy with cares and stated the skin breakdown areas FM-A found was a big concern. The DON stated she talked with nurses on each shift regarding importance of repositioning, toileting and keeping the moisture away from the areas because of the identified skin areas. The DON stated she did make the staff aware that family was not happy

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2 830	Continued From page 17 with this situation. The DON stated staff indicated they did reposition and toilet R1 frequently. The DON stated she was drinking lots of pop and water, so she was continuously needing to void and was also on fluid pills. The DON stated she did explain to FM-A R1 would often refuse repositioning and once the skin issues were identified, she was more accepting of the repositioning and would lay down in bed. The Skin Management Program policy and procedure revised February 2019 included, "All residents will be assessed for skin integrity or changes in skin conditions upon preadmission screening, daily with POC (point of care) and weekly with bath." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for non pressure related skin concerns to assure they are receiving the necessary treatment/services to prevent non pressure related skin concerns from developing and to promote healing of non pressure related skin concerns. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk of non pressure related skin concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		