Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 5, 2026

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

RE: CCN: 245536
Cycle Start Date: April 8, 2026

Dear Administrator:

On April 8, 2026, a survey was completed at your facility by the Minnesota Department of Health 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 July 8, 2026 (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 October 8, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

Re: State Nursing Home Licensing Orders
Event ID: 1DEDC4-H1

Dear Administrator:

The above facility survey was completed on April 8, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - 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.

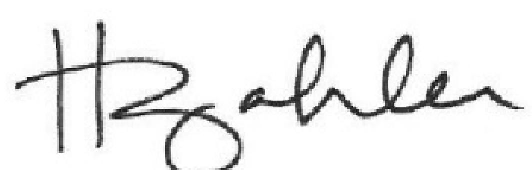
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245536**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**
NAME OF PROVIDER OR SUPPLIER **Green Lea Senior Living**		STREET ADDRESS, CITY, STATE, ZIP CODE **115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 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
F0000	INITIAL COMMENTS On 4/6/26 through 4/8/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55361078C (2972076), H55368263C (2673289), H55361122C (2974871) with citations at F684 and F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/11/2026
F0684 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: Based on observation, interview and documentation, the facility failed to comprehensively assess and	F0684	F684 R3 is currently in the hospital. A comprehensive wound assessment, including wound measurements will be completed on day of readmission to the facility. Wound Care policy and procedure was reviewed and updated on 5/6/2026. All current residents in the facility who currently have a wound were audited to ensure they had a comprehensive wound assessment, including measurements completed in the past week. Facility has updated its process to have Director of Nursing, or RN designee in DON absence completing wound rounds weekly to ensure a comprehensive wound assessment, including measurements, is	05/16/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER: **Green Lea Senior Living**		STREET ADDRESS, CITY, STATE, ZIP CODE: **115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 55954**	

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F0684 SS = D	Continued from page 1 monitor a wound for 1 of 3 residents (R3) reviewed for wound care. Findings include: R3's diagnoses list dated 4/7/26 included orthopedic aftercare following surgical amputation, acquired absence of right leg below the knee, and other complications of amputation stump. R3's significant change Minimum Data Set (MDS) dated 12/24/26 identified R3 did not have cognitive impairment. R3's received surgical wound care. R3's care plan dated 3/24/26 indicated a risk for impaired skin integrity related to surgical intervention right below the knee amputation (BKA), decreased mobility and need for assistance with personal cares. Interventions included but were not limited to dressing change every other day initiated on 3/31/26 and evaluate skin integrity. The care plan also included R3 has peripheral vascular disease (PVD) related to diabetes mellitus type 2 and hypertensive heart disease with chronic kidney disease. Interventions included but were not limited to BKA related to PVD: right leg: inspect incisions daily, drain in place, cover with gauze and abdominal pad followed by stump protector initiated on 3/17/26. R3's outside wound care provider note dated 3/23/26 indicated R3's wound drain was removed on 3/23/26. R3's wound care order dated 3/23/26 instructed: dressing change every other day to right stump wound. Irrigate with normal saline (water) and dry. Pack wound with Mesalt ribbon (narrow strip of gauze dressing) in wound 5.5 centimeters going almost straight down. Cover with Mepilex border dressing (a foam wound dressing). R3's progress note dated 4/5/26 at 4:20 p.m. indicated wound care was provided as ordered. Moderate amount of sanguineous and purulent drainage. Tunneling approximately 7-7.5cm. Peri wound saturated with brown, yellow, and green drainage. No odor. Surrounding tissue pink. Leg dry and flaky, lotion applied. Resident denied pain or discomfort. In review of R3's wound documentation records between 3/1/26 and 4/5/26 revealed although there were wound mentions with descriptions the assessments/monitoring there was no indication a comprehensive assessment was completed that included measurements in order to determine improvement or deterioration.	F0684	Continued from page 1 completed and documented per policy weekly. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All registered nurses who will be completing the required weekly comprehensive wound assessment, including measurements will be educated on the facility policy Wound Care by compliance date. Education included: ensuring residents who have a wound are assessed weekly, and includes the required comprehensive wound assessment documentation, including measurements per facility policy. Education on the policy was initiated on 5/7/26. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. The Nurse Consultant will complete audits on 3 random residents who have wounds weekly for 3 months to ensure comprehensive wound assessment, including measurements that are completed per facility policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: May 16, 2026	05/16/2026

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NAME OF PROVIDER OR SUPPLIER: **Green Lea Senior Living**		STREET ADDRESS, CITY, STATE, ZIP CODE: **115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 55954**	

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F0684 SS = D	Continued from page 2 During an observation on 4/6/2026 at 4:18 p.m. R3 was sitting in a wheelchair with his right leg elevated in a padded brace with Velcro straps. During an interview, R3 stated he had a wound to his right stump that had been giving him trouble. He was going to an outside wound care provider who assessed the wound and took measurements. R3 could not recall the last time a facility nurse measured the wound. During an interview on 4/6/2026 at 4:32 p.m., licensed practical nurse (LPN)-a stated there was an order on the resident's TAR to measure wounds once a week. The measurements would be written down in the wound book. Every resident wound had a page in the book. A registered nurse needed to complete the weekly wound measurements and assessments. During an observation on 4/7/2026 at 9:43 a.m., R3's wound page was observed in the wound care binder. Weekly dates were entered along with dressing change order. The page did not include measurements nor characteristics of the wound. During an interview, registered nurse (RN)-A stated Friday was wound measurement day. Measurements were documented in the weekly wound care binder. Description of the wound characteristics wound be documented in a wound note. Monitoring of the wound was done with every dressing change. RN-A confirmed the weekly wound care binder did not contain measurements of R3's wound. RN-A stated she was uncertain whether she would measure R3's wound on Fridays because he was seen by an outside wound care provider every other week who measured the wound. RN-A stated she would look for a wound note in R3's chart or the wound care provider notes to determine if the wound was improving or deteriorating. During an interview on 4/8/2026 9:46 a.m., medical doctor (MD) stated nurses should be documenting what a wound looks like with every dressing change and measured at least weekly. MD expected to be notified if a wound was deteriorating. MD would ask the nurse about R3's wound because she could not rely on documentation in the chart for description of the wounds. MD did not know about the book with weekly wound measurements. Measurements and a description of the wound were especially important for R3 because his wound had deteriorated several times so the wound needed close monitoring. During an interview on 4/8/2026 at 10:48 a.m. nurse consultant (NC) stated the director of nursing (DON)	F0684		05/16/2026

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F0684 SS = D	Continued from page 3 would add an order to the resident's TAR for wound measurement on Fridays when an RN was working. NC stated R3's wound note on 4/5/26 was a good description of the wound but did not contain measurements. NC confirmed R3's did not contain weekly wound assessments in March 2026 or April 2026. A resident's wound should be measured weekly and a wound note written with the measurements and the nurse's assessment of the wound. The Wound Care policy dated 10/15/24 instructed the following information should be recorded in the resident's medical record: The type of wound care given. The date and time the wound care was given. The name and title of the individual performing the wound care. Any change in the resident's condition. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound, weekly and as needed by wound nurse. Any problems or complaints made by the resident related to the procedure. If the resident refused the treatment and the reason(s) why. The signature and title of the person recording the data.	F0684		05/16/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F0755	F755 Reconciliation and accounting of all controlled medications stored in the emergency medication kit was completed on 5/7/2026. Medication count was accurate and there were no concerns noted. There are no resident home medications currently being stored at the facility. Controlled Substance Storage policy and procedure was reviewed and updated on 5/6/2026. The facility created an E-Kit reconciliation form to be used when a medication is removed from the E-Kit, and documentation of shift-to-shift count is completed. Medications Brought to the Facility by a Resident or	05/16/2026

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F0755 SS = D	Continued from page 4 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to establish a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications stored in an emergency medication kit and failed to establish a system to account for medications brought from home and stored in the medication room. Findings include: During an observation on 4/7/2026 at 9:43 a.m., registered nurse (RN)-A was observed unlocking the medication room then unlocking a cabinet to access the emergency medication kits (e-kit). A small e-kit was labeled with a list of controlled medications including the number of stocked pills/bottles and was secured with a breakaway lock with numbers. A larger e-kit labeled with non-controlled medications was also secured with a breakaway lock with numbers. A binder was observed with an every shift listing of lock numbers and staff initials. During an interview, RN-A stated to remove a controlled medication the nurse would first check the resident's provider orders. If the order matched a medication in the e-kit, the nurse would break the lock on the e-kit, fill out the pharmacy usage form, remove the required medication, then place a new lock on the e-kit and record the new lock number in the binder. The usage form would be faxed to pharmacy then placed in a basket on the counter to be scanned into the resident's medical record. If the number of pills in the e-kit did not match the	F0755	Continued from page 4 Responsible Party policy and procedure was reviewed and updated on 5/6/2026. Facility has updated its admission/re-admission checklist to include home medication inventory documentation Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All licensed nurses will be educated on the facility policy: Medications Brought to the Facility by a Resident or Responsible Party by compliance date. Education included: ensuring nurses receiving home medications from residents complete the home medication inventory form and scan into the resident chart. Education on the policy was initiated on 5/7/26. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. All licensed nurses/TMA's will be educated on the facility policy: Controlled Substance Storage by compliance date. Education included: the new E-Kit reconciliation form to be used when a medication is removed from the E-Kit, and documentation of shift-to-shift count is completed on the E-Kit. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. The Director of Nursing will complete an audit once weekly on all resident home medications to ensure if the facility has any resident home medications on site, that the home medications inventory form is completed per policy. Director of Nursing will complete twice weekly audit on the E-kit reconciliation form to ensure E-Kit medications are accounted for, along with shift-to-shift count is completed on the E-kit controlled medications. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: May 16, 2026	05/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026
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F0755 SS = D	Continued from page 5 number indicated on the cover of the controlled e-kit, RN-A would contact the pharmacy to find out when the other pills had been removed. RN-A further stated if a resident admitted with home medications, the nurse would ask a family member to bring the medications home. If there were no family members available, the medications would be placed in the medication room until the resident discharged or the medications were destroyed with resident or family approval. RN-A did not know if there was a procedure to account for a resident's home non-controlled medications that were stored in the medication room. During an interview on 4/6/2026 at 4:32 p.m., licensed practical nurse (LPN)-A stated when a resident brings medications from home, the nurse would ask family to bring the medications home. If that was not possible, the medications would written down on a piece of paper, the medications placed into a plastic bag, list of medications attached to the bag, then the bag placed in the medication room. During an observation on 4/7/2026 at 11:35 a.m., trained medication assistant (TMA)-A opened an unlocked cabinet in the medication room and removed a gallon size bag filled with medication bottles. During an interview, TMA-A stated when a resident brought medications from home, the nurse would go through the bag to look for controlled medications then would give the bag to TMA-A to place in a medication room cabinet. TMA-A did not know what the procedure was to account for all the non-controlled medications a resident brought from home. During an interview on 4/7/2026 at 12:31 p.m., pharmacist (Ph) stated the facility should be accounting for all medications removed from the e-kit and complete an inventory every shift. E-kits were replaced at the pharmacy's discretion and might need to be accessed several times before replacement. During an interview on 4/7/2026 at 11:54 p.m. director of nursing (DON) stated a nurse should count the pills in the controlled e-kit before removing any medications and compare the number of pills in the e-kit with the number of stocked pills on the top of the e-kit. If the numbers are different, the nurse would look at the pharmacy usage sheet that was placed in the e-kit from a previous medication removal. If there were no completed sheets in the e-kit, the nurse should call the pharmacy for information about any pills that had been removed since the last e-kit replacement.	F0755		05/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Lea Senior Living	**115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 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
F0755 SS = D	Continued from page 6 During an interview on 4/8/2026 at 9:59 a.m., the nurse consultant (NC) stated when a resident brings medications from home, a nurse would ask family to take the medications out of the facility. If there is no one to take the medications, a nurse should document all the medications including the number of pills in a nurse’s note in the resident’s electronic medical record. The Controlled Substance Storage policy dated 4/1/2019 instructed at each shift change or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented. The Medications Brought to the Facility by a Resident or Responsible Party policy dated 4/1/19 instructed a licensed nurse to receive the medication delivered to the facility and documented delivery of the medication on the appropriate form/chart.	F0755		05/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Lea Senior Living	**115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 55954**

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20000	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 4/6/26 through 4/8/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55361078C (2972076), H55368263C (2673289),	20000		05/11/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**
NAME OF PROVIDER OR SUPPLIER **Green Lea Senior Living**		STREET ADDRESS, CITY, STATE, ZIP CODE **115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 55954**	

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20000	Continued from page 1 H55361122C (2974871) with a licensing orders issued at 20875 and 21600. 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 surveyor's 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility 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.	20000		05/11/2026
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration,	20875	F684 R3 is currently in the hospital. A comprehensive wound assessment, including wound measurements will be completed on day of readmission to the facility. Wound Care policy and procedure was reviewed and updated on 5/6/2026.	05/16/2026

Minnesota Department of Health

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20875	Continued from page 2 and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and documentation, the facility failed to comprehensively assess and monitor a wound for 1 of 3 residents (R3) reviewed for wound care. Findings include: R3's diagnoses list dated 4/7/26 included orthopedic aftercare following surgical amputation, acquired absence of right leg below the knee, and other complications of amputation stump. R3's significant change Minimum Data Set (MDS) dated 12/24/26 identified R3 did not have cognitive impairment. R3's received surgical wound care. R3's care plan dated 3/24/26 indicated a risk for impaired skin integrity related to surgical intervention right below the knee amputation (BKA), decreased mobility and need for assistance with personal cares. Interventions included but were not limited to dressing change every other day initiated on 3/31/26 and evaluate skin integrity. The care plan also included R3 has peripheral vascular disease (PVD) related to diabetes mellitus type 2 and hypertensive heart disease with chronic kidney disease. Interventions included but were not limited to BKA related to PVD: right leg: inspect incisions daily, drain in place, cover with gauze and abdominal pad followed by stump protector initiated on 3/17/26. R3's outside wound care provider note dated 3/23/26 indicated R3's wound drain was removed on 3/23/26. R3's wound care order dated 3/23/26 instructed: dressing change every other day to right stump wound. Irrigate with normal saline (water) and dry. Pack wound with Mesalt ribbon (narrow strip of gauze dressing) in wound 5.5 centimeters going almost straight down. Cover with Mepilex border dressing (a foam wound dressing). R3's progress note dated 4/5/26 at 4:20 p.m. indicated wound care was provided as ordered. Moderate amount of sanguineous and purulent drainage. Tunneling approximately 7-7.5cm. Peri wound saturated with brown, yellow, and green drainage. No odor. Surrounding tissue pink. Leg dry and flaky, lotion applied. Resident denied pain or discomfort.	20875	Continued from page 2 All current residents in the facility who currently have a wound were audited to ensure they had a comprehensive wound assessment, including measurements completed in the past week. Facility has updated its process to have Director of Nursing, or RN designee in DON absence completing wound rounds weekly to ensure a comprehensive wound assessment, including measurements, is completed and documented per policy weekly. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All registered nurses who will be completing the required weekly comprehensive wound assessment, including measurements will be educated on the facility policy Wound Care by compliance date. Education included: ensuring residents who have a wound are assessed weekly, and includes the required comprehensive wound assessment documentation, including measurements per facility policy. Education on the policy was initiated on 5/7/26. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. The Nurse Consultant will complete audits on 3 random residents who have wounds weekly for 3 months to ensure comprehensive wound assessment, including measurements that are completed per facility policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: May 16, 2026	05/16/2026

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20875	Continued from page 3 In review of R3's wound documentation records between 3/1/26 and 4/5/26 revealed although there were wound mentions with descriptions the assessments/monitoring there was no indication a comprehensive assessment was completed that included measurements in order to determine improvement or deterioration. During an observation on 4/6/2026 at 4:18 p.m. R3 was sitting in a wheelchair with his right leg elevated in a padded brace with Velcro straps. During an interview, R3 stated he had a wound to his right stump that had been giving him trouble. He was going to an outside wound care provider who assessed the wound and took measurements. R3 could not recall the last time a facility nurse measured the wound. During an interview on 4/6/2026 at 4:32 p.m., licensed practical nurse (LPN)-a stated there was an order on the resident's TAR to measure wounds once a week. The measurements would be written down in the wound book. Every resident wound had a page in the book. A registered nurse needed to complete the weekly wound measurements and assessments. During an observation on 4/7/2026 at 9:43 a.m., R3's wound page was observed in the wound care binder. Weekly dates were entered along with dressing change order. The page did not include measurements nor characteristics of the wound. During an interview, registered nurse (RN)-A stated Friday was wound measurement day. Measurements were documented in the weekly wound care binder. Description of the wound characteristics wound be documented in a wound note. Monitoring of the wound was done with every dressing change. RN-A confirmed the weekly wound care binder did not contain measurements of R3's wound. RN-A stated she was uncertain whether she would measure R3's wound on Fridays because he was seen by an outside wound care provider every other week who measured the wound. RN-A stated she would look for a wound note in R3's chart or the wound care provider notes to determine if the wound was improving or deteriorating. During an interview on 4/8/2026 9:46 a.m., medical doctor (MD) stated nurses should be documenting what a wound looks like with every dressing change and measured at least weekly. MD expected to be notified if a wound was deteriorating. MD would ask the nurse about R3's wound because she could not rely on documentation in the chart for description of	20875		05/16/2026

Minnesota Department of Health

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20875	Continued from page 4 the wounds. MD did not know about the book with weekly wound measurements. Measurements and a description of the wound were especially important for R3 because his wound had deteriorated several times so the wound needed close monitoring. During an interview on 4/8/2026 at 10:48 a.m. nurse consultant (NC) stated the director of nursing (DON) would add an order to the resident's TAR for wound measurement on Fridays when an RN was working. NC stated R3's wound note on 4/5/26 was a good description of the wound but did not contain measurements. NC confirmed R3's did not contain weekly wound assessments in March 2026 or April 2026. A resident's wound should be measured weekly and a wound note written with the measurements and the nurse's assessment of the wound. The Wound Care policy dated 10/15/24 instructed the following information should be recorded in the resident's medical record: The type of wound care given. The date and time the wound care was given. The name and title of the individual performing the wound care. Any change in the resident's condition. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound, weekly and as needed by wound nurse. Any problems or complaints made by the resident related to the procedure. If the resident refused the treatment and the reason(s) why. The signature and title of the person recording the data. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all resident skin concerns are assessed by a registered nurse and provider notified. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.	20875		05/16/2026

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20875	Continued from page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20875		05/16/2026
21600	Stock Medications; Emergency Supply CFR(s): MN Rule 4658.1335 Subp. 2 Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to establish a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications stored in an emergency medication kit and failed to establish a system to account for medications brought from home and stored in the medication room. Findings Include During an observation on 4/7/2026 at 9:43 a.m., registered nurse (RN)-A was observed unlocking the medication room then unlocking a cabinet to access the emergency medication kits (e-kit). A small e-kit was labeled with a list of controlled medications including the number of stocked pills/bottles and was secured with a breakaway lock with numbers. A larger e-kit labeled with non-controlled medications was also secured with a breakaway lock with numbers. A binder was observed with every shift listing of lock numbers and staff initials. During an interview, RN-A stated to remove a controlled medication the nurse would first check the resident's provider orders. If the order matched a medication in the e-kit, the nurse would break the lock on the e-kit, fill out the pharmacy usage form, remove the required medication, then place a new lock on the e-kit and record the new lock number in the binder. The usage form would be faxed to pharmacy then placed in a basket on the counter to be scanned into the resident's medical record. If the number of pills in the e-kit did not match the number indicated on the cover of the controlled e-kit, RN-A would contact the pharmacy to find out when the other pills had been removed. RN-A further stated if a resident admitted with home medications, the nurse would ask a family member to bring the medications home. If there were no family members available, the medications would be	21600	F755 Reconciliation and accounting of all controlled medications stored in the emergency medication kit was completed on 5/7/2026. Medication count was accurate and there were no concerns noted. There are no resident home medications currently being stored at the facility. Controlled Substance Storage policy and procedure was reviewed and updated on 5/6/2026. The facility created an E-Kit reconciliation form to be used when a medication is removed from the E-Kit, and documentation of shift-to-shift count is completed. Medications Brought to the Facility by a Resident or Responsible Party policy and procedure was reviewed and updated on 5/6/2026. Facility has updated its admission/re-admission checklist to include home medication inventory documentation Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All licensed nurses will be educated on the facility policy: Medications Brought to the Facility by a Resident or Responsible Party by compliance date. Education included: ensuring nurses receiving home medications from residents complete the home medication inventory form and scan into the resident chart. Education on the policy was initiated on 5/7/26. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. All licensed nurses/TMA's will be educated on the facility policy: Controlled Substance Storage by compliance date. Education included: the new E-Kit reconciliation form to be used when a medication is removed from the E-Kit, and documentation of shift-to-shift count is completed on the E-Kit. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift.	05/16/2026

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21600	Continued from page 6 placed in the medication room until the resident discharged or the medications were destroyed with resident or family approval. RN-A did not know if there was a procedure to account for a resident's home non-controlled medications that were stored in the medication room. During an interview on 4/6/2026 at 4:32 p.m., licensed practical nurse (LPN)-A stated when a resident brings medications from home, the nurse would ask family to bring the medications home. If that was not possible, the medications would be written down on a piece of paper, the medications placed into a plastic bag, list of medications attached to the bag, then the bag placed in the medication room. During an observation on 4/7/2026 at 11:35 a.m., trained medication assistant (TMA)-A opened an unlocked cabinet in the medication room and removed a gallon size bag filled with medication bottles. During an interview, TMA-A stated when a resident brought medications from home, the nurse would go through the bag to look for controlled medications then would give the bag to TMA-A to place in a medication room cabinet. TMA-A did not know what the procedure was to account for all the non-controlled medications a resident brought from home. During an interview on 4/7/2026 at 12:31 p.m., pharmacist (Ph) stated the facility should be accounting for all medications removed from the e-kit and complete an inventory every shift. E-kits were replaced at the pharmacy's discretion and might need to be accessed several times before replacement. During an interview on 4/7/2026 at 11:54 p.m. director of nursing (DON) stated a nurse should count the pills in the controlled e-kit before removing any medications and compare the number of pills in the e-kit with the number of stocked pills on the top of the e-kit. If the numbers are different, the nurse would look at the pharmacy usage sheet that was placed in the e-kit from a previous medication removal. If there were no completed sheets in the e-kit, the nurse should call the pharmacy for information about any pills that had been removed since the last e-kit replacement. During an interview on 4/8/2026 at 9:59 a.m., the nurse consultant (NC) stated when a resident brings medications from home, a nurse would ask family to take the medications out of the facility. If there is no one to take the medications, a nurse should	21600	Continued from page 6 The Director of Nursing will complete an audit once weekly on all resident home medications to ensure if the facility has any resident home medications on site, that the home medications inventory form is completed per policy. Director of Nursing will complete twice weekly audit on the E-kit reconciliation form to ensure E-Kit medications are accounted for, along with shift-to-shift count is completed on the E-kit controlled medications. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: May 16, 2026	05/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

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21600	Continued from page 7 document all the medications including the number of pills in a nurse’s note in the resident’s electronic medical record. The Controlled Substance Storage policy dated 4/1/2019 instructed at each shift change or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented. The Medications Brought to the Facility by a Resident or Responsible Party policy dated 4/1/19 instructed a licensed nurse to receive the medication delivered to the facility and documented delivery of the medication on the appropriate form/chart. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications stored in an emergency medication kit and a system to account for medications brought from home and stored in the medication room. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		05/16/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 1, 2026

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

RE: CCN: 245536
Cycle Start Date: April 8, 2026

Dear Administrator:

On May 21, 2026, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2026

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

Re: Reinspection Results
Event ID: 1DEDC4-H1

Dear Administrator:

On May 21, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 8, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us