Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2024

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

RE: CCN: 245536
Cycle Start Date: March 26, 2024

Dear Administrator:

On May 2, 2024, we notified you a remedy was imposed. On June 5, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 31, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 26, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 2, 2004, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 26, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 31, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

June 20, 2024

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

RE: Project Number

Dear Administrator:

On June 5, 2024, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $350.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on June 5, 2024 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $350.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $255.20, are to be added to the total amount of the assessment. **You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $605.20 within 15 days of the receipt of this notice.** That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

cc: Joanne Simon, Federal Enforcement Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 13, 2024

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

RE: CCN: 245536
Cycle Start Date: March 26, 2024

Dear Administrator:

On May 2, 2024 we informed you of imposed enforcement remedies.

On May 2, 2024, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

The deficiency not corrected is as follows:

F686 - Treatment/svcs To Prevent/health Pressure Ulcer

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 26, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 26, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 26, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 26, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Green Lea Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 26, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 26, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 _____	R-C 05/02/2024

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 5/1/24 and 5/2/24, an offsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited on 3/26/24. The facility was NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55362260C (MN00101784) with a deficiency reissued at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	{F 686}		5/31/24

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

Electronically Signed | 05/23/2024

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

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{F 686}	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess pressure ulcers, follow physician ordered treatments to prevent and/or mitigate the risk of new ulcer development or deterioration, and notify the physician that orders for treatment were not followed for 2 of 4 residents (R4, R5) reviewed for pressure ulcers. In addition, the facility failed to revise the care plan to include a newly noted pressure ulcer for 1 of 4 residents (R4) reviewed. Finding include: Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis (middle layer of skin), presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Fat is not visible and deeper tissues are not visible. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable (able to be felt) fascia (connective tissues), muscle, tendon, ligament, cartilage or bone in the ulcer. Slough (non-viable usually moist tissue than can be soft and stringy in texture) and/or eschar (dead or devitalized tissue that is usually black and may appear scab-like) may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. R4's Minimum Data Set (MDS) dated 3/27/24, indicated R4 admitted on 11/23 with diagnoses including hypertension, non-rheumatic aortic	{F 686}	F 686 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 686, Treatment/Svcs to Prevent/Heal Pressure Ulcer, Green Lea Senior Living corrected the deficiency by reviewing R4, R5 and all like residents for accurate comprehensive skin and positioning assessment, accurate body audits, physician ordered treatments were being followed, physician notification if treatments not followed, and care plans updated with skin concerns by 5/31/2024.	

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{F 686}	Continued From page 2 valve stenosis (narrowing or blockage of a valve in the heart), prediabetes, and chronic obstructive pulmonary disease. R5 was identified as at risk of developing pressure ulcers/injuries with no current unhealed pressure ulcers/injuries. R4's last completed Comprehensive Skin and Positioning Evaluation dated 3/21/24, noted R4 did not have any current wounds or alterations in skin integrity. A progress noted dated 4/25/24, indicated a 1 centimeter (cm) by 3 cm open area on R4's coccyx (tailbone) and the wound nurse, family, and physician were notified. It directed to see adverse event charting for more details. R4's adverse event charting titled #512 New Skin Area dated 4/25/24, included a description of the incident noting a small open area on the coccyx was reported by a certified nursing assistant and was an approximately 2 cm x 1 cm slit. Immediate action taken noted the area was assessed, a padded adhesive dressing was applied, and the wound nurse was notified. R4's Ulcer Skin Assessment dated 4/25/24, was a paper form not present in R4's electronic health record (EHR) completed by the facility's wound care nurse, registered nurse (RN)-A. It noted a stage 2 pressure ulcer on R4's coccyx, facility acquired, measurements 1 cm by 3 cm, scant serosanguinous exudate, no tunneling or undermining, red wound bed, pink surrounding skin, intact surrounding tissue/wounds edges, no pain, and dietary/provider/family date notified of 4/25/24. The tissue type section was blank. A Fax Communication with Provider form with	{F 686}	2. To correct the deficiency and to ensure the problem does not recur all nurses were educated on 5/8/2024 or prior to next shift on Comprehensive Skin Assessment completion, Body Audit completion, Physician Notification, Following physician orders and the Accura Skin Process by the DON. DON and/or Designee will audit comprehensive skin and positioning evaluations to ensure those at risk have interventions added to care plan to prevent skin alterations weekly x 12 weeks and then randomly to ensure continued compliance. DON and/or Designee will audit body audits for accuracy and completion 3 times per week for 12 weeks and then randomly to ensure continued compliance. DON and/or Designee will audit residents with skin alterations to ensure Accura Skin Process was followed, care plan updated, physician treatment orders were being followed, and physician was notified if treatment orders were not followed weekly x 12 weeks and then randomly to ensure continued compliance. DON and/or designee will audit all new admissions for accurate comprehensive skin assessment with interventions care planned as appropriate, weekly body audit assigned to TAR, accurate physician orders, and physician/family/POA notification for any new skin concerns	

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{F 686}	Continued From page 3 date received 4/25/24 at 2:44 p.m., included message to provider from facility of "Concern: (1 c[m] x 3cm) open area by coccyx, treated with padded drsg [dressing], anything else?" with a provider response of "monitor for worsening daily. Continue Mepi border [Mepilex, an adhesive foam dressing] for protection, offload regularly." The facility's Skin Integrity Rolling Log (electronic document used to track current alterations in skin integrity for all residents, not part of individual EHRs) for April 2024, noted R4 had a facility acquired stage 2 pressure injury dated 4/25/24, location coccyx, measurements on 4/25/24 of 1 cm x 3 cm, cause: pressure, treatment: per provider 4/25/24; Mepilex daily for protection, 4/26/24 referral to wound clinic. The added to care plan, physician notified, family notified, and progress note updated boxes were checked indicating completion. R4's weekly Body Audit assessment dated 4/29/24, marked "no" to the prompt "Does the resident have any alteration in skin integrity (which may include by not limited to bruising, skin tears, scars, surgical incisions, rashes, IV sites, burns, implanted ports, pressure, vascular, or diabetic ulcers." The overall summary section was blank. It did not include any documentation of R4's stage 2 pressure ulcer. R4's Comprehensive Skin and Positioning Evaluation dated 5/1/24, was in progress but had not yet been completed and was blank. A physician order in R4's EHR with creation date of 5/1/24, instructed staff to apply a Mepilex to coccyx daily for protection and monitor for worsening one time a day every day and as	{F 686}	weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community□s QA Process.	

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{F 686}	Continued From page 4 needed. The order was created and entered in R4's electronic health record (EHR) on 5/1/24 at 12:05 p.m. by the director of nursing (DON) and had a start date of 5/2/24 at 7:00 a.m. The faxed provider order was previously received by the facility on 4/25/24. R4's Treatment Administration Record (TAR) for April 2024, did not include the provider wound care orders for application of a Mepilex dressing and wound monitoring. There was no documentation that this task was completed. R4's TAR for May 2024, included "Mepilex to coccyx daily for protection. Monitor for worsening. One time a day" and included documentation of completion at 7:00 a.m. on 5/2/24. No other administrations of the treatment were documented. In review of R4's EHR, documentation indicating the provider was notified of the delay in entry and completion of the pressure ulcer wound care orders was not identified. R4's care plan included a focus on skin with revision date 5/1/24, included R4 had an actual impairment in skin integrity related to rosacea (inflammatory skin condition causing redness, usually on the face), lichen sclerosis et atrophicus (inflammatory skin condition causing thin skin), incontinence of bowel and bladder, and pressure stage 2 area to coccyx noted 4/25/24. Interventions included an intervention dated 5/1/24, treatment as ordered, notify medical practitioner if skin alteration worsening or no improvement for 14 days. Prior to this revision, R4's skin care plan did not include the stage 2 pressure ulcer and was last updated 12/11/23.	{F 686}		

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{F 686}	Continued From page 5 In an interview on 5/2/24 at 10:23 a.m., RN-A stated if staff found a new pressure injury, they completed an ulcer assessment paper sheet which was turned in to her and she then measured the ulcers weekly and continued the documentation on this sheet. RN-A stated the sheets were kept in a binder in her office and an active wound wouldn't necessarily be in a resident's EHR yet, she did her best to scan/upload the sheets as fast as she could. RN-A stated a nurse would also notify the provider, family, and DON and executive director and write a progress note. RN-A noted comprehensive assessments of pressure injuries included the ulcer assessment sheets, weekly body audits, and the facility's Comprehensive Skin and Positioning Evaluations. RN-A noted Comprehensive Skin and Positioning Evaluations were completed quarterly and whenever a new wound was identified. RN-A confirmed R4's last Comprehensive Skin and Positioning Evaluation was started on 5/1/24, her coccyx pressure wound was identified on 4/25/24, and she would expect that the assessment would have been completed as soon as possible and this was not in line with her expectation. RN-A confirmed R4's last Body Audit was from 4/29/24 and did not identify her coccyx pressure wound. RN-A noted there was a progress note made on the day the pressure wound was identified, but it was not comprehensive and the coccyx pressure wound was not comprehensively assessed on the body audit or Comprehensive Skin and Positioning Evaluation. RN-A stated she had the paper ulcer assessment from 4/25 for the coccyx pressure wound which she considered comprehensive, but stated it did not identify risk factors. RN-A noted wound measurements were on the ulcer sheets	{F 686}		

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	245536	A. BUILDING _____ B. WING _____	R-C 05/02/2024

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

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{F 686}	Continued From page 6	{F 686}		

in her office and she would need to provide information to floor nurses about the wounds she was monitoring in order for them to accurately monitor the wounds because they did not have all the information needed to monitor for improvement or worsening.

In the same interview on 5/2/24 at 10:23 a.m., RN-A identified herself as responsible for updating skin care plans, stated they should be updated as soon as possible when new skin concerns are identified, and confirmed the coccyx stage 2 pressure ulcer was not added to R4's care plan until 5/1/24. RN-A stated the facility's Rolling Skin Log indicated R4's care plan was updated on 4/25/24, but this was not accurate. RN-A stated the wound care orders for R4's coccyx pressure ulcer were a Mepilex to the coccyx daily and to monitor for worsening. RN-A stated the orders were received on 4/25/24 and put in R4's chart on 5/1/24 with a start date for staff to follow the order and do the treatment on 5/2/24. RN-A stated the nurses on the floor were responsible for putting in new orders received from providers and she was not sure why it was delayed. RN-A noted R4 not receiving treatment per orders created risks of infection or worsening of the wound.

In an interview on 5/2/24 at 3:09 p.m., the DON stated for floor nurses there should be wound measurements in the Body Audit assessments and if the measurements were not there it would be difficult for a nurse to monitor a wound because they would not know the size. The DON stated wound care and dressing changes were based on provider orders that go into the EHR, they were typically received via fax, and she would expect the faxed orders to be checked at

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least once per shift. The DON noted R4 had the new coccyx wounds and the wound care orders didn't get put in, the paper fax was uploaded to R4's EHR but no orders were entered. The DON stated she knew a Mepilex dressing was placed on R4 when the wound was identified, but she could not say if the Mepilex was changed daily since then because the order was not entered. The DON noted RN-A was typically responsible for updating care plans and for a new skin alteration she would expect it to be updated within 48 hours. The DON stated she could not say if R4 did or did not get treatment per provider orders, there was no documentation to verify the treatment was done which was especially concerning for pressure ulcers.

R5's facesheet dated 5/2/24, indicated R5 was admitted on 4/29/24 with diagnoses including lumbar spina bifida (area of spine and spinal column not developed properly), atherosclerotic heart disease (narrowing/hardening of arteries due to plaque build-up), abdominal aortic aneurysm without rupture (bulging and weakening of the aortic artery in the abdomen), hypertensive heart and chronic kidney disease with heart failure, peripheral vascular disease (a circulatory disorder leading to decreased blood flow to limbs), iron deficiency anemia (lack of healthy red blood cells), colostomy, artificial opening of urinary tract, acquired absence of left great toe (left big toe amputation), stage 4 pressure ulcer of right buttock, paraplegia (lower body paralysis), chronic combined systolic and diastolic congestive heart failure (inability of the heart to pump blood effectively), and dependence on a wheelchair.

R5's hospital Discharge Summary provider note

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{F 686}	Continued From page 8 dated 4/29/24, noted R5 had a stage 4 right ischial tuberosity (bones in the lower pelvis also known as the sit bones) pressure injury with possible pending flap surgery (a reconstructive surgery to promote healing of advanced stage pressure injuries). R5's hospital After Visit Summary dated 4/29/24, included skin/wound/dressing care instructions for "pressure injury stage 4 ischial tuberosity right" of "see non-vascular wound service note/recommendations (4/29/2024)." Underneath these directions was a bulleted list as follows, "Your wound has healed and the skin is fragile, it will take some time for it to strengthen; it may never be the same strength as skin that has not been damaged; it is more prone to breaking down again; check this area frequently for new breakdown; keep it clean and dry; you may keep it covered if it will protect it or help to keep it dry; keep pressure off this area and try not to let things rub on it, this could be rubbing from scooting in a chair or sliding down in bed; use a cushion in your chair, elevate your feet and legs if able; change your position frequently." R5's non-vascular wound service hospital provider note dated 4/29/24, included "I have evaluated patient's right ischial wound and scrotal wound prior to leaving today. I have transition[ed] to dry packing of the right ischium with a 4 x 4 gauze [four inch by four inch gauze pad] and ABD pad [abdominal pad, an absorbent non-woven pad dressing] 2 to 3 times a day ... Dry packing right ischium 2 to 3 times a day with dry Kerlix [rolled gauze] cover[ed] with ABD pad and tape." R5's progress note dated 4/29/24, indicated R5 arrived at the facility at 3:10 p.m. from a hospital	{F 686}		

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where he was admitted on 4/8/24, he had an extensive health history with long-term disability, he had spina bifida with paraplegia, a stage 4 sacral pressure injury as well as multiple other skin issues, a colostomy and urostomy, was alert and oriented, and reported he anticipated a four to six week stay before returning to the hospital for skin flap surgery.

A physician order in R5's EHR with start date of 4/29/24, noted "Pressure injury stage 4 ischial tuberosity right; Resolved, your wound has healed. Check this area frequently for new breakdown. Keep it clean and dry. Keep pressure off of this area. Use a cushion in your chair. Elevate your feet and legs if able. Change your position frequently" three times a day every day. The order was discontinued on 5/1/24 at 4:39 p.m.

R5's TAR documented this treatment was completed on the 4/29/24 overnight (10:00 p.m. to 6:00 a.m.) shift, on the 4/30/24 daytime (6:00 a.m. to 2:00 p.m.) evening (2:00 p.m. to 10:00 p.m.) and overnight shifts, and on the 5/1/24 day shift.

R5's Nursing Assessment:
Admission/Readmission dated 4/29/24, included a skin integrity section with a pre-populated list. Types of skin alteration present selected were pressure ulcer, other ulcer, moisture associated skin damage, and abrasion. The skin treatments/interventions to manage/prevent alterations in skin integrity pre-populated options selected were pressure reducing device(s) for bed, pressure ulcer care, application of non-surgical dressings, application of ointment/medications. The body audit section

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included identification of a stage 4 pressure injury on the right tuberosity. The measurements were left blank.

R5's Ulcer Skin Assessment dated 4/30/24, was a paper form not present in R4's electronic health record (EHR) completed by the facility's wound care nurse, registered nurse (RN)-A. It noted a stage 4 pressure ulcer on admission, located on the right ischial tuberosity, with measurements of 8 cm x 7.5 cm x 2 cm, moderate serous drainage, no odor, no tunneling or undermining, a red/pink wound bed, pink surrounding skin within normal limits, intact surrounding tissue/wound edges, 100% granulation tissue, and no pain.

The facility's Skin Integrity Rolling Log for April 2024, noted R5 had a stage 4 pressure injury on admission, location right ischial tuberosity, measurements dated 4/30/24 of 8 cm by 7.5 cm by 2 cm, cause: pressure, treatment: dry packing three times a day covered with OptiLock (non-adhesive absorbent dressing) held in place with a sacral border (Mepilex). The added to care plan, physician notified, family notified, and progress note updated boxes were checked yes indicating completion.

R5's Body Audit assessment dated 4/30/24, noted R5 had alterations in skin integrity including: "healed area on right heel, scab on amputated left great toe, wound on inner left ankle, healed area on coccyx, pressure wound to right sacrum, healed friction area to nose, penis erosions." No further information about the wounds or pressure ulcer was included and the overall summary section was blank.

R5's admission Comprehensive Skin and

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{F 686}	Continued From page 11 Positioning Evaluation dated 4/30/23, identified the following from pre-populated lists. Diseases/conditions that present complications or increase risk factors for altered skin integrity section included: Neurological - other (explain other field was not completed), circulatory/heart - none of the above, pulmonary - other (explain other field was not completed), musculoskeletal - plegia, metabolic - other (explain other field was not completed), gastrointestinal - none of the above, genitourinary - none of the above, other diseases/conditions - none of the above, infections - wound infections, nutritional - none of the above. The treatment and other risk factors section included: treatments - other (explain other field was not completed), and other risk factors - newly admitted or readmitted/confined to bed or chair all or most of the day/requires staff assistance to move sufficiently. The medications section marked other (explain other field was not completed). The Braden Scale (assessment for predicting pressure sore risk) section had a score of 15, indicating R5 was at high risk. The skin conditions section included: resident has a pressure ulcer/injury or a scar over bony prominence or a non-removable dressing or device, other open lesion(s) on the foot, very thin fragile skin, and current pressure ulcers. The approaches/interventions section included: turning/repositioning program, pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet, and application of ointments/medications other than to feet. No skin care plan interventions were selected from the available list and the summary/comments section was blank. R5's Ulcer Skin Assessment dated 5/1/24, was a	{F 686}		

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{F 686}	Continued From page 12 paper form not present in R4's electronic health record (EHR) completed by the facility's wound care nurse, registered nurse (RN)-A. It noted the stage 4 pressure ulcer on the right ischial tuberosity measured 8 cm x 7.5 cm x 2 cm with moderate serous drainage, no odor, no tunneling or undermining, a pink/red wound bed, pink surrounding skin within normal limits, intact surrounding tissue/wound edges, not changed since last assessment, treatment marked "changes" with recommendation listed of three times daily dry packing with 4 x 4 gauze and ABD pad, 100% granulation tissue, and no pain. A physician order in R5's EHR with creation date of 5/1/24 at 4:40 p.m., instructed staff "Pressure injury stage 5 right ischial tuberosity; Dry packing with a 4 x 4 gauze and ABD pad TID [three times a day]" to be done three times a day every day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. with a start date of 5/1/24 at 8:00 p.m. entered by RN-A. In review of R5's TAR, documentation indicating this treatment was completed prior to the entry of the order on 5/1/24 was not identified. In review of R5's EHR, documentation indicating the provider was notified of the delay in entry and completion of the pressure ulcer wound care orders was not identified. When the survey began on 5/1/24, R5's baseline care plan was still in development because he had not yet been admitted for 48 hours. This was in accordance with facility policy. In an interview on 5/2/24 at 10:23 a.m., RN-A stated R5 was admitted with a stage 4 left ischial pressure ulcer on 4/29 and had a Comprehensive	{F 686}		

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{F 686}	Continued From page 13 Skin and Positioning assessment done on 4/30. RN-A noted the areas marked "other" under risk factors lacked explanations and R5's diagnoses of lumbar spina bifida, atherosclerotic heart disease, abdominal aortic aneurysm, hypertensive heart and kidney disease, peripheral vascular disease, chronic combined systolic and diastolic congestive heart failure, acquired absence of left great toe were not listed and she would have included them. RN-A stated the assessment was not accurate and complete, R5's wounds had not been comprehensively assessed, and this was not in line with her expectations. In the same interview on 5/2/24 at 10:23 a.m., RN-A confirmed wound care orders for R5's ischial pressure wound were entered on 5/1/24 and directed staff to dry pack the wound with 4 x 4 gauze and ABD pads three times daily. RN-A stated R5 came with an after visit summary note that said to see the non-vascular wound service note from 4/29/24 for wound care instructions, but they did not have that note at the time. RN-A stated her expectation would be that the facility would contact the provider for clarification. RN-A noted prior to 5/1/24, the treatment for R5's stage 4 pressure ulcer was what the discharge summary said, the order did not constitute wound care, it was not appropriate, and R5 did not receive appropriate wound care and treatment for the stage 4 pressure ulcer from 4/29/24 to 5/1/24. RN-A identified this created a risk for infection and worsening of the wound. RN-A stated staff noticed the orders were incorrect and she utilized an online EHR linking system to retrieve the non-vascular wound note with orders from 4/29/24. RN-A stated she did not see any documentation that the provider was notified of	{F 686}		

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the lack of wound care and the provider should have been notified as soon as the discrepancy was identified.

In an interview on 5/2/24 at 1:11 p.m., RN-A stated on 4/30/24 she removed the gauze in the wound, ABD pad and tape on top, and measured R5's wound. RN-A stated she re-dressed the wound after in the same manner with new gauze, ABD pad, and tape. RN-A noted this should have alerted her to the problem because there were no proper dressing orders in R5's chart for the wound. RN-A noted that she had access to the non-vascular wound care note with orders through the EHR linking system any time but retrieved it the day before, 5/1/24 at 4:20 p.m., changed the wound care order in the computer, and then re-measured R5's wound and changed the dressing. She stated she did not notify the provider. RN-A stated she did not have any documentation to show other dressing changes were done, the order wasn't in.

In an interview on 5/2/24 at 2:55 p.m., RN-B stated she worked the 2:00 p.m. to 10:00 p.m. shift on 4/30/29 and the dressing change orders for R5's ischial tuberosity pressure ulcer were new to her, they were not in his chart on Tuesday. She stated on 4/30/24 she was only to change a dressing on his coccyx.

In an interview on 5/2/24 at 3:09 p.m., the DON stated the wound care orders for R5's stage 4 pressure ulcer were confusing, the original order said his wound was healed, but it was not healed. This issue was not something she had been made aware of. The DON stated nursing should have notified the provider that they needed orders for the wound care or reached out to her to see if

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she could find anything, the order said it was healed and it was clearly not, something needed to be said. The DON noted both she and RN-A had access to the EHR linking system. The DON stated once staff had orders, the treatment should have been done right away and she would expect the provider to be notified. The DON identified a stage 4 pressure ulcer not getting ordered treatments had an increased change of infection and could worsen or progress to sepsis (an extreme bodily reaction to infection that is life-threatening). The DON stated she did not know how someone would know what to do for a dressing change or wound care without orders, someone should not pack a wound without orders. The DON was unable to verify R5 had received the ordered treatment for his pressure ulcer prior to the entry of the new order on 5/1/24.

Facility policy titled Notification of Change in Resident Health Status dated 2/8/23, included: "The resident's physician and resident's legal representative will be notified of a change in resident status when the following occur ... B) A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. C) A need to alter treatment significantly, for example a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment."

Facility policy titled Skin Management Protocol dated 5/16/23, included: "Wound Notification Standards: A) Notify DON and Wound Nurse of new skin alteration or skin ulcer; B) Complete incident report in Risk Management [electronic

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health record] and Skin Sheet (paper); C) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated weekly by designated Wound Nurse; D) The community will report to the physician if there is any deterioration or signs of infection is [sic] observed ...Follow the Wound Care Guidelines on the Accura Dimes Protocol that was created with [consultant] or physician orders."

Facility policy titled Weekly Skin Assessment and Documentation Process dated 1/20/23, included "Skin ulcers and non-ulcers will be assessed and documented weekly by the facility wound nurse ... Assessment and Documentation Process: B) Identifying a Skin Ulcer or Non-Ulcer Assessment: 1) The nurse who initially identifies the Skin Ulcer or Non-Ulcer Ulcer [sic] will complete the appropriate Skin Assessment ... 4) The Nurse Leader will fax the appropriate wound treatment order per the Accura Skin/Wound Protocol for approval by the physician 5) The Care Plan will be updated and reviewed to ensure that the skin/wound alteration and appropriate interventions have been identified on the Care Plan."

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2024

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

RE: CCN: 245536
Cycle Start Date: March 26, 2024

Dear Administrator:

On March 26, 2024, a survey was completed at your facility by the Minnesota Departments 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 June 26, 2024 (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 September 26, 2024 (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,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 _____	R-C 05/02/2024

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) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/1/24 and 5/2/24, an offsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 3/26/24 by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was	{2 000}		

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{2 000}	Continued From page 1 issued. The complaint H55362260C (MN00101784) which was found to be out of compliance and issued at (0900) at the time of the survey, remained out of compliance. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	{2 000}		

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{2 000}	Continued From page 2 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.	{2 000}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess pressure ulcers, follow physician ordered treatments to prevent and/or mitigate the risk of new ulcer development or deterioration, and notify the physician that orders for treatment were not followed for 2 of 4 residents (R4, R5) reviewed for	{2 900}	F 686 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	5/31/24

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{2 900}	Continued From page 3 pressure ulcers. In addition, the facility failed to revise the care plan to include a newly noted pressure ulcer for 1 of 4 residents (R4) reviewed. Finding include: Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis (middle layer of skin), presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Fat is not visible and deeper tissues are not visible. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable (able to be felt) fascia (connective tissues), muscle, tendon, ligament, cartilage or bone in the ulcer. Slough (non-viable usually moist tissue than can be soft and stringy in texture) and/or eschar (dead or devitalized tissue that is usually black and may appear scab-like) may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. R4's Minimum Data Set (MDS) dated 3/27/24, indicated R4 admitted on 11/23 with diagnoses including hypertension, non-rheumatic aortic valve stenosis (narrowing or blockage of a valve in the heart), prediabetes, and chronic obstructive pulmonary disease. R5 was identified as at risk of developing pressure ulcers/injuries with no current unhealed pressure ulcers/injuries. R4's last completed Comprehensive Skin and Positioning Evaluation dated 3/21/24, noted R4 did not have any current wounds or alterations in skin integrity. A progress noted dated 4/25/24, indicated a 1 centimeter (cm) by 3 cm open area on R4's	{2 900}	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 686, Treatment/Svcs to Prevent/Heal Pressure Ulcer, Green Lea Senior Living corrected the deficiency by reviewing R4, R5 and all like residents for accurate comprehensive skin and positioning assessment, accurate body audits, physician ordered treatments were being followed, physician notification if treatments not followed, and care plans updated with skin concerns by 5/31/2024. 2. To correct the deficiency and to ensure the problem does not recur all nurses were educated on 5/8/2024 or prior to next shift on Comprehensive Skin Assessment completion, Body Audit completion, Physician Notification, Following physician orders and the Accura Skin Process by the DON. DON and/or Designee will audit comprehensive skin and positioning evaluations to ensure those at risk have interventions added to care plan to	

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{2 900}	Continued From page 4 coccyx (tailbone) and the wound nurse, family, and physician were notified. It directed to see adverse event charting for more details. R4's adverse event charting titled #512 New Skin Area dated 4/25/24, included a description of the incident noting a small open area on the coccyx was reported by a certified nursing assistant and was an approximately 2 cm x 1 cm slit. Immediate action taken noted the area was assessed, a padded adhesive dressing was applied, and the wound nurse was notified. R4's Ulcer Skin Assessment dated 4/25/24, was a paper form not present in R4's electronic health record (EHR) completed by the facility's wound care nurse, registered nurse (RN)-A. It noted a stage 2 pressure ulcer on R4's coccyx, facility acquired, measurements 1 cm by 3 cm, scant serosanguinous exudate, no tunneling or undermining, red wound bed, pink surrounding skin, intact surrounding tissue/wounds edges, no pain, and dietary/provider/family date notified of 4/25/24. The tissue type section was blank. A Fax Communication with Provider form with date received 4/25/24 at 2:44 p.m., included message to provider from facility of "Concern: (1 c[m] x 3cm) open area by coccyx, treated with padded drsg [dressing], anything else?" with a provider response of "monitor for worsening daily. Continue Mepi border [Mepilex, an adhesive foam dressing] for protection, offload regularly." The facility's Skin Integrity Rolling Log (electronic document used to track current alterations in skin integrity for all residents, not part of individual EHRs) for April 2024, noted R4 had a facility acquired stage 2 pressure injury dated 4/25/24, location coccyx, measurements on 4/25/24 of 1	{2 900}	prevent skin alterations weekly x 12 weeks and then randomly to ensure continued compliance. DON and/or Designee will audit body audits for accuracy and completion 3 times per week for 12 weeks and then randomly to ensure continued compliance. DON and/or Designee will audit residents with skin alterations to ensure Accura Skin Process was followed, care plan updated, physician treatment orders were being followed, and physician was notified if treatment orders were not followed weekly x 12 weeks and then randomly to ensure continued compliance. DON and/or designee will audit all new admissions for accurate comprehensive skin assessment with interventions care planned as appropriate, weekly body audit assigned to TAR, accurate physician orders, and physician/family/POA notification for any new skin concerns weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community□s QA Process.	

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{2 900}	Continued From page 5 cm x 3 cm, cause: pressure, treatment: per provider 4/25/24; Mepilex daily for protection, 4/26/24 referral to wound clinic. The added to care plan, physician notified, family notified, and progress note updated boxes were checked indicating completion. R4's weekly Body Audit assessment dated 4/29/24, marked "no" to the prompt "Does the resident have any alteration in skin integrity (which may include by not limited to bruising, skin tears, scars, surgical incisions, rashes, IV sites, burns, implanted ports, pressure, vascular, or diabetic ulcers." The overall summary section was blank. It did not include any documentation of R4's stage 2 pressure ulcer. R4's Comprehensive Skin and Positioning Evaluation dated 5/1/24, was in progress but had not yet been completed and was blank. A physician order in R4's EHR with creation date of 5/1/24, instructed staff to apply a Mepilex to coccyx daily for protection and monitor for worsening one time a day every day and as needed. The order was created and entered in R4's electronic health record (EHR) on 5/1/24 at 12:05 p.m. by the director of nursing (DON) and had a start date of 5/2/24 at 7:00 a.m. The faxed provider order was previously received by the facility on 4/25/24. R4's Treatment Administration Record (TAR) for April 2024, did not include the provider wound care orders for application of a Mepilex dressing and wound monitoring. There was no documentation that this task was completed. R4's TAR for May 2024, included "Mepilex to coccyx daily for protection. Monitor for worsening.	{2 900}		

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{2 900}	Continued From page 6 One time a day" and included documentation of completion at 7:00 a.m. on 5/2/24. No other administrations of the treatment were documented. In review of R4's EHR, documentation indicating the provider was notified of the delay in entry and completion of the pressure ulcer wound care orders was not identified. R4's care plan included a focus on skin with revision date 5/1/24, included R4 had an actual impairment in skin integrity related to rosacea (inflammatory skin condition causing redness, usually on the face), lichen sclerosis et atrophicus (inflammatory skin condition causing thin skin), incontinence of bowel and bladder, and pressure stage 2 area to coccyx noted 4/25/24. Interventions included an intervention dated 5/1/24, treatment as ordered, notify medical practitioner if skin alteration worsening or no improvement for 14 days. Prior to this revision, R4's skin care plan did not include the stage 2 pressure ulcer and was last updated 12/11/23. In an interview on 5/2/24 at 10:23 a.m., RN-A stated if staff found a new pressure injury, they completed an ulcer assessment paper sheet which was turned in to her and she then measured the ulcers weekly and continued the documentation on this sheet. RN-A stated the sheets were kept in a binder in her office and an active wound wouldn't necessarily be in a resident's EHR yet, she did her best to scan/upload the sheets as fast as she could. RN-A stated a nurse would also notify the provider, family, and DON and executive director and write a progress note. RN-A noted comprehensive assessments of pressure injuries included the ulcer assessment sheets, weekly	{2 900}		

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{2 900}	Continued From page 7 body audits, and the facility's Comprehensive Skin and Positioning Evaluations. RN-A noted Comprehensive Skin and Positioning Evaluations were completed quarterly and whenever a new wound was identified. RN-A confirmed R4's last Comprehensive Skin and Positioning Evaluation was started on 5/1/24, her coccyx pressure wound was identified on 4/25/24, and she would expect that the assessment would have been completed as soon as possible and this was not in line with her expectation. RN-A confirmed R4's last Body Audit was from 4/29/24 and did not identify her coccyx pressure wound. RN-A noted there was a progress note made on the day the pressure wound was identified, but it was not comprehensive and the coccyx pressure wound was not comprehensively assessed on the body audit or Comprehensive Skin and Positioning Evaluation. RN-A stated she had the paper ulcer assessment from 4/25 for the coccyx pressure wound which she considered comprehensive, but stated it did not identify risk factors. RN-A noted wound measurements were on the ulcer sheets in her office and she would need to provide information to floor nurses about the wounds she was monitoring in order for them to accurately monitor the wounds because they did not have all the information needed to monitor for improvement or worsening. In the same interview on 5/2/24 at 10:23 a.m., RN-A identified herself as responsible for updating skin care plans, stated they should be updated as soon as possible when new skin concerns are identified, and confirmed the coccyx stage 2 pressure ulcer was not added to R4's care plan until 5/1/24. RN-A stated the facility's Rolling Skin Log indicated R4's care plan was updated on 4/25/24, but this was not accurate. RN-A stated the wound care orders for R4's	{2 900}		

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{2 900}	Continued From page 8 coccyx pressure ulcer were a Mepilex to the coccyx daily and to monitor for worsening. RN-A stated the orders were received on 4/25/24 and put in R4's chart on 5/1/24 with a start date for staff to follow the order and do the treatment on 5/2/24. RN-A stated the nurses on the floor were responsible for putting in new orders received from providers and she was not sure why it was delayed. RN-A noted R4 not receiving treatment per orders created risks of infection or worsening of the wound. In an interview on 5/2/24 at 3:09 p.m., the DON stated for floor nurses there should be wound measurements in the Body Audit assessments and if the measurements were not there it would be difficult for a nurse to monitor a wound because they would not know the size. The DON stated wound care and dressing changes were based on provider orders that go into the EHR, they were typically received via fax, and she would expect the faxed orders to be checked at least once per shift. The DON noted R4 had the new coccyx wounds and the wound care orders didn't get put in, the paper fax was uploaded to R4's EHR but no orders were entered. The DON stated she knew a Mepilex dressing was placed on R4 when the wound was identified, but she could not say if the Mepilex was changed daily since then because the order was not entered. The DON noted RN-A was typically responsible for updating care plans and for a new skin alteration she would expect it to be updated within 48 hours. The DON stated she could not say if R4 did or did not get treatment per provider orders, there was no documentation to verify the treatment was done which was especially concerning for pressure ulcers. R5's facesheet dated 5/2/24, indicated R5 was	{2 900}		

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{2 900}	Continued From page 9 admitted on 4/29/24 with diagnoses including lumbar spina bifida (area of spine and spinal column not developed properly), atherosclerotic heart disease (narrowing/hardening of arteries due to plaque build-up), abdominal aortic aneurysm without rupture (bulging and weakening of the aortic artery in the abdomen), hypertensive heart and chronic kidney disease with heart failure, peripheral vascular disease (a circulatory disorder leading to decreased blood flow to limbs), iron deficiency anemia (lack of healthy red blood cells), colostomy, artificial opening of urinary tract, acquired absence of left great toe (left big toe amputation), stage 4 pressure ulcer of right buttock, paraplegia (lower body paralysis), chronic combined systolic and diastolic congestive heart failure (inability of the heart to pump blood effectively), and dependence on a wheelchair. R5's hospital Discharge Summary provider note dated 4/29/24, noted R5 had a stage 4 right ischial tuberosity (bones in the lower pelvis also known as the sit bones) pressure injury with possible pending flap surgery (a reconstructive surgery to promote healing of advanced stage pressure injuries). R5's hospital After Visit Summary dated 4/29/24, included skin/wound/dressing care instructions for "pressure injury stage 4 ischial tuberosity right" of "see non-vascular wound service note/recommendations (4/29/2024)." Underneath these directions was a bulleted list as follows, "Your wound has healed and the skin is fragile, it will take some time for it to strengthen; it may never be the same strength as skin that has not been damaged; it is more prone to breaking down again; check this area frequently for new breakdown; keep it clean and dry; you may keep	{2 900}		

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{2 900}	Continued From page 10 it covered if it will protect it or help to keep it dry; keep pressure off this area and try not to let things rub on it, this could be rubbing from scooting in a chair or sliding down in bed; use a cushion in your chair, elevate your feet and legs if able; change your position frequently." R5's non-vascular wound service hospital provider note dated 4/29/24, included "I have evaluated patient's right ischial wound and scrotal wound prior to leaving today. I have transition[ed] to dry packing of the right ischium with a 4 x 4 gauze [four inch by four inch gauze pad] and ABD pad [abdominal pad, an absorbent non-woven pad dressing] 2 to 3 times a day ... Dry packing right ischium 2 to 3 times a day with dry Kerlix [rolled gauze] cover[ed] with ABD pad and tape." R5's progress note dated 4/29/24, indicated R5 arrived at the facility at 3:10 p.m. from a hospital where he was admitted on 4/8/24, he had an extensive health history with long-term disability, he had spina bifida with paraplegia, a stage 4 sacral pressure injury as well as multiple other skin issues, a colostomy and urostomy, was alert and oriented, and reported he anticipated a four to six week stay before returning to the hospital for skin flap surgery. A physician order in R5's EHR with start date of 4/29/24, noted "Pressure injury stage 4 ischial tuberosity right; Resolved, your wound has healed. Check this area frequently for new breakdown. Keep it clean and dry. Keep pressure off of this area. Use a cushion in your chair. Elevate your feet and legs if able. Change your position frequently" three times a day every day. The order was discontinued on 5/1/24 at 4:39 p.m.	{2 900}		

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 _____	R-C 05/02/2024

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{2 900}	Continued From page 11 R5's TAR documented this treatment was completed on the 4/29/24 overnight (10:00 p.m. to 6:00 a.m.) shift, on the 4/30/24 daytime (6:00 a.m. to 2:00 p.m.) evening (2:00 p.m. to 10:00 p.m.) and overnight shifts, and on the 5/1/24 day shift. R5's Nursing Assessment: Admission/Readmission dated 4/29/24, included a skin integrity section with a pre-populated list. Types of skin alteration present selected were pressure ulcer, other ulcer, moisture associated skin damage, and abrasion. The skin treatments/interventions to manage/prevent alterations in skin integrity pre-populated options selected were pressure reducing device(s) for bed, pressure ulcer care, application of non-surgical dressings, application of ointment/medications. The body audit section included identification of a stage 4 pressure injury on the right tuberosity. The measurements were left blank. R5's Ulcer Skin Assessment dated 4/30/24, was a paper form not present in R4's electronic health record (EHR) completed by the facility's wound care nurse, registered nurse (RN)-A. It noted a stage 4 pressure ulcer on admission, located on the right ischial tuberosity, with measurements of 8 cm x 7.5 cm x 2 cm, moderate serous drainage, no odor, no tunneling or undermining, a red/pink wound bed, pink surrounding skin within normal limits, intact surrounding tissue/wound edges, 100% granulation tissue, and no pain. The facility's Skin Integrity Rolling Log for April 2024, noted R5 had a stage 4 pressure injury on admission, location right ischial tuberosity, measurements dated 4/30/24 of 8 cm by 7.5 cm by 2 cm, cause: pressure, treatment: dry packing	{2 900}		

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{2 900}	Continued From page 12 three times a day covered with OptiLock (non-adhesive absorbent dressing) held in place with a sacral border (Mepilex). The added to care plan, physician notified, family notified, and progress note updated boxes were checked yes indicating completion. R5's Body Audit assessment dated 4/30/24, noted R5 had alterations in skin integrity including: "healed area on right heel, scab on amputated left great toe, wound on inner left ankle, healed area on coccyx, pressure wound to right sacrum, healed friction area to nose, penis erosions." No further information about the wounds or pressure ulcer was included and the overall summary section was blank. R5's admission Comprehensive Skin and Positioning Evaluation dated 4/30/23, identified the following from pre-populated lists. Diseases/conditions that present complications or increase risk factors for altered skin integrity section included: Neurological - other (explain other field was not completed), circulatory/heart - none of the above, pulmonary - other (explain other field was not completed), musculoskeletal - plegia, metabolic - other (explain other field was not completed), gastrointestinal - none of the above, genitourinary - none of the above, other diseases/conditions - none of the above, infections - wound infections, nutritional - none of the above. The treatment and other risk factors section included: treatments - other (explain other field was not completed), and other risk factors - newly admitted or readmitted/confined to bed or chair all or most of the day/requires staff assistance to move sufficiently. The medications section marked other (explain other field was not completed). The Braden Scale (assessment for predicting pressure sore risk) section had a score	{2 900}		

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{2 900}	Continued From page 13 of 15, indicating R5 was at high risk. The skin conditions section included: resident has a pressure ulcer/injury or a scar over bony prominence or a non-removable dressing or device, other open lesion(s) on the foot, very thin fragile skin, and current pressure ulcers. The approaches/interventions section included: turning/repositioning program, pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet, and application of ointments/medications other than to feet. No skin care plan interventions were selected from the available list and the summary/comments section was blank. R5's Ulcer Skin Assessment dated 5/1/24, was a paper form not present in R4's electronic health record (EHR) completed by the facility's wound care nurse, registered nurse (RN)-A. It noted the stage 4 pressure ulcer on the right ischial tuberosity measured 8 cm x 7.5 cm x 2 cm with moderate serous drainage, no odor, no tunneling or undermining, a pink/red wound bed, pink surrounding skin within normal limits, intact surrounding tissue/wound edges, not changed since last assessment, treatment marked "changes" with recommendation listed of three times daily dry packing with 4 x 4 gauze and ABD pad, 100% granulation tissue, and no pain. A physician order in R5's EHR with creation date of 5/1/24 at 4:40 p.m., instructed staff "Pressure injury stage 5 right ischial tuberosity; Dry packing with a 4 x 4 gauze and ABD pad TID [three times a day]" to be done three times a day every day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. with a start date of 5/1/24 at 8:00 p.m. entered by RN-A. In review of R5's TAR, documentation indicating	{2 900}		

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{2 900}	Continued From page 14 this treatment was completed prior to the entry of the order on 5/1/24 was not identified. In review of R5's EHR, documentation indicating the provider was notified of the delay in entry and completion of the pressure ulcer wound care orders was not identified. When the survey began on 5/1/24, R5's baseline care plan was still in development because he had not yet been admitted for 48 hours. This was in accordance with facility policy. In an interview on 5/2/24 at 10:23 a.m., RN-A stated R5 was admitted with a stage 4 left ischial pressure ulcer on 4/29 and had a Comprehensive Skin and Positioning assessment done on 4/30. RN-A noted the areas marked "other" under risk factors lacked explanations and R5's diagnoses of lumbar spina bifida, atherosclerotic heart disease, abdominal aortic aneurysm, hypertensive heart and kidney disease, peripheral vascular disease, chronic combined systolic and diastolic congestive heart failure, acquired absence of left great toe were not listed and she would have included them. RN-A stated the assessment was not accurate and complete, R5's wounds had not been comprehensively assessed, and this was not in line with her expectations. In the same interview on 5/2/24 at 10:23 a.m., RN-A confirmed wound care orders for R5's ischial pressure wound were entered on 5/1/24 and directed staff to dry pack the wound with 4 x 4 gauze and ABD pads three times daily. RN-A stated R5 came with an after visit summary note that said to see the non-vascular wound service note from 4/29/24 for wound care instructions, but they did not have that note at the time. RN-A	{2 900}		

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{2 900}	Continued From page 15 stated her expectation would be that the facility would contact the provider for clarification. RN-A noted prior to 5/1/24, the treatment for R5's stage 4 pressure ulcer was what the discharge summary said, the order did not constitute wound care, it was not appropriate, and R5 did not receive appropriate wound care and treatment for the stage 4 pressure ulcer from 4/29/24 to 5/1/24. RN-A identified this created a risk for infection and worsening of the wound. RN-A stated staff noticed the orders were incorrect and she utilized an online EHR linking system to retrieve the non-vascular wound note with orders from 4/29/24. RN-A stated she did not see any documentation that the provider was notified of the lack of wound care and the provider should have been notified as soon as the discrepancy was identified. In an interview on 5/2/24 at 1:11 p.m., RN-A stated on 4/30/24 she removed the gauze in the wound, ABD pad and tape on top, and measured R5's wound. RN-A stated she re-dressed the wound after in the same manner with new gauze, ABD pad, and tape. RN-A noted this should have alerted her to the problem because there were no proper dressing orders in R5's chart for the wound. RN-A noted that she had access to the non-vascular wound care note with orders through the EHR linking system any time but retrieved it the day before, 5/1/24 at 4:20 p.m., changed the wound care order in the computer, and then re-measured R5's wound and changed the dressing. She stated she did not notify the provider. RN-A stated she did not have any documentation to show other dressing changes were done, the order wasn't in. In an interview on 5/2/24 at 2:55 p.m., RN-B stated she worked the 2:00 p.m. to 10:00 p.m.	{2 900}		

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{2 900}	Continued From page 16 shift on 4/30/29 and the dressing change orders for R5's ischial tuberosity pressure ulcer were new to her, they were not in his chart on Tuesday. She stated on 4/30/24 she was only to change a dressing on his coccyx. In an interview on 5/2/24 at 3:09 p.m., the DON stated the wound care orders for R5's stage 4 pressure ulcer were confusing, the original order said his wound was healed, but it was not healed. This issue was not something she had been made aware of. The DON stated nursing should have notified the provider that they needed orders for the wound care or reached out to her to see if she could find anything, the order said it was healed and it was clearly not, something needed to be said. The DON noted both she and RN-A had access to the EHR linking system. The DON stated once staff had orders, the treatment should have been done right away and she would expect the provider to be notified. The DON identified a stage 4 pressure ulcer not getting ordered treatments had an increased change of infection and could worsen or progress to sepsis (an extreme bodily reaction to infection that is life-threatening). The DON stated she did not know how someone would know what to do for a dressing change or wound care without orders, someone should not pack a wound without orders. The DON was unable to verify R5 had received the ordered treatment for his pressure ulcer prior to the entry of the new order on 5/1/24. Facility policy titled Notification of Change in Resident Health Status dated 2/8/23, included: "The resident's physician and resident's legal representative will be notified of a change in resident status when the following occur ... B) A significant change in the resident's physical, mental, or psychosocial status for example, a	{2 900}		

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{2 900}	Continued From page 17 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. C) A need to alter treatment significantly, for example a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment." Facility policy titled Skin Management Protocol dated 5/16/23, included: "Wound Notification Standards: A) Notify DON and Wound Nurse of new skin alteration or skin ulcer; B) Complete incident report in Risk Management [electronic health record] and Skin Sheet (paper); C) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated weekly by designated Wound Nurse; D) The community will report to the physician if there is any deterioration or signs of infection is [sic] observed ...Follow the Wound Care Guidelines on the Accura Dimes Protocol that was created with [consultant] or physician orders." Facility policy titled Weekly Skin Assessment and Documentation Process dated 1/20/23, included "Skin ulcers and non-ulcers will be assessed and documented weekly by the facility wound nurse ... Assessment and Documentation Process: B) Identifying a Skin Ulcer or Non-Ulcer Assessment: 1) The nurse who initially identifies the Skin Ulcer or Non-Ulcer Ulcer [sic] will complete the appropriate Skin Assessment ... 4) The Nurse Leader will fax the appropriate wound treatment order per the Accura Skin/Wound Protocol for approval by the physician 5) The Care Plan will be updated and reviewed to ensure that the skin/wound alteration and appropriate interventions have been identified on the Care Plan."	{2 900}		

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{2 900}	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee could also review all residents with pressure ulcers to assure the wounds are comprehensively assessed and included in comprehensive person-centered care plans. The DON or designee could conduct audits of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee could also conduct audits of pressure ulcer assessments to ensure assessments are comprehensive and accurate. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{2 900}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 2F9N11

Dear Administrator:

The above facility was surveyed on March 25, 2024 through March 26, 2024 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2024

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

RE: CCN: 245536
Cycle Start Date: March 26, 2024

Dear Administrator:

On March 26, 2024, a survey was completed at your facility by the Minnesota Departments 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 June 26, 2024 (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 September 26, 2024 (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,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 03/26/2024

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 3/25/24, and 3/26/24, 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: H55362260C (MN00101784) with a deficiency cited at F580 and F686 H55362300C (MN0010193) with deficiency cited at F657 H55362322C (MN00101910) H55362323C (MN00101903) . The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		4/26/24

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

Electronically Signed | 04/19/2024

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

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F 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure physician notification of skin injury that required treatment for 1 of 3 residents (R1) reviewed for pressure ulcers. The findings include: R1's face sheet printed 3/25/24, included diagnoses of chronic right heart failure, acute respiratory failure, type 2 diabetes mellitus with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes. High blood sugar [glucose] can injure nerves throughout the body.), type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone) stage 2, non-pressure ulcer of other part of right foot with fat layer exposed. R1's quarterly Minimum Data Set (MDS) dated 3/1/24, indicated R1 had moderate cognitive impairment, R1 was at risk for pressure ulcers, had one unhealed stage 2 pressure ulcer (partial thickness loss of dermis [The inner layer of the two main layers of the skin] presenting as a shallow open ulcer with a red or pink wound bed, without slough. May present as an intact or open/ruptured serum filled blister.) MDS did not identify any other skin concerns such as other infections of the foot, diabetic foot ulcers, or open lesions on the foot, nor did it identify any other skin concerns present during assessment. Skin treatments included pressure ulcer care,	F 580	F 580 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 580, Notify of Changes, Green Lea Senior Living corrected the deficiency by ensuring all residents with skin alterations had appropriate notification to physician and family/POA by the Director of Nursing and/or designee by 04/26/2024. R1 was discharged from the facility on 04/11/2024. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 04/26/2024 or prior to their	

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F 580	Continued From page 3 application of ointment/medications other to feet, and application of dressings to feet. R1's care plan revised on 9/20/23, identified R1 had a pressure injury on left buttock, diabetic ulcer on right great toe, injury on left great toe and moisture associated skin damage (MASD.). R1's progress note dated 3/9/24, documented registered nurse (RN) and nursing assistant (NA) noted old appearing bandage to left lower leg, lateral aspect, below knee. The bandage was peeling off and had a small amount of dried blood that was now very brown and hardened. Under the bandage was a wound of unknown cause. It had the appearance of possible impact wound and/or pressure injury. It was irregular round area approximately larger than a quarter. Measurements not obtained at this time. Wound was deep red and purple mix with a dark purple mix with dark brownish center that appears to have been open and now healing over with a new layer of skin. There was no drainage currently. The area appeared to be discolored and quite raised, hard and not fluid filled. More so resembled a bruise. Possibly area of impact from being bumped. R1 has been quite deconditioned with recent poor health, therefore has not been common for him to leave the bed recently, if at all. R1 insists on keeping several items in the bed with him at all times, along with several remotes. R1 denied pain when area was assessed. It does not appear R1 typically has prolonged pressure to this outer area of his leg. Director of nursing [DON] noted to be notified of injury at this time as RN was unable to find documentation of area. Wound appeared to be 1-2 days old. Wound left dry and covered with padded bandage to protect.	F 580	next shift on Notification of Change in Resident Health Status Policy by the Director of Nursing. The Director of Nursing and/or designee will audit 3 residents with skin alterations for appropriate family and physician notification weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 580	Continued From page 4 R1's Skin Integrity log for the Left lateral knee dated 3/11/24, indicated the wound was facility acquired abrasion Measured 0.7 cm x 0.8 cm. Added to care plan, doctor and family notified. In review of R1's record between 3/9/24 to 3/18/24, it was not evident the physician was notified of R1's left lateral knee wound. Additionally, there was no indication of a physician ordered treatment in that time frame. During an interview on 3/25/24 at 12:51 p.m., family member (FM)-A indicated she had come in for a visit around 3/9/24 noted the leg wound when she was putting lotion on R1's legs and he yelled in pain when she got close to the wound that was covered with a bandage with no date on it. FM-A stated she later noted what appeared to be the same bandage in place on the wound a week later, she brought it to the physician's attention on 3/18/24. Physician had lifted the bandage and put the same bandage back on around 8:30 a.m., physician gave an order for the dressing to be completed daily around 3/18/24. However, later the same day R1 was sent to ER in late afternoon around 2:30 p.m. for breathing concerns and returned from the hospital between 8:30p.m. and 9:30 p.m. and dressing had not been changed. R1's physician assistant (PA) visit dated 3/18/24, included "It was noticed over the last coupe of days that he has a new wound over his left lateral leg. This is presumably from pressure. He has a reacher that he holds himself and keeps in his bed, and his [family member] wonders if perhaps the reacher got underneath him for a period of time and contributed to the pressure." Physical examination included: On the right lateral heel,	F 580		

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F 580	Continued From page 5 there is a small area of redness, about 0.5 cm in diameter, non-blanching and the overlying skin appeared to be intact. Left lateral knee there appeared about a 2 cm in diameter with skin breakdown and black necrotic area in the middle with some moist serous drainage on the overlying from dressing. The note indicated PA ordered Arginaid wound protein supplement, "He [R1] needs repositioning every 2 hours" Additional treatment orders included, continue skin prep daily to the right heel wound with pressure offloading cushion. For the leg wound that is deep tissue injury, "we will trim calcium alginate or Aquacel [non-stick antimicrobial wound dressing] to fit the wound and apply this to the wound bed daily. Cover with bordered foam dressing and change daily. R1's March 2024 treatment administration record (TAR) identified the aforementioned treatment plan that was identified in the physician note; the knee dressing identified a start date of 3/19/24. During an observation on 3/25/24 at 1:28 p.m., registered nurse (RN)-A was providing wound cares. Left lower area below the knee had a gauze dressing wrapped around the leg that was not dated. RN-A indicated it was not an expectation the dressing be dated and was not able to articulate how long the wrong dressing according to treatment orders had been on. The gauze was dry and adhered to the wound. RN-A sprayed the gauze with wound cleanser to moisten the gauze and carefully and slowly started unwrapping the dressing. Despite R1 being medicated with narcotic pain medication R1 cried out in pain and displayed facial grimacing as RN-A removed the dressing. The leg wound appeared dark black in color about a quarter or	F 580		

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F 580	Continued From page 6 larger with bright red skin surrounding the wound. When RN attempted to touch R1's left leg during wound care R1 again cried out in pain. New dressing was applied at this time as ordered. RN-A noted left heal to be soft and spongy at this time. During an interview on 3/26/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated she documented the leg injury for R1 on the 3/11/24 body audit but did not notify the doctor of the injury. LPN-A stated she had faxed the provider about a deep tissue injury on his right heel on 3/7/24 and thought she had provided information about the leg wound on that same fax as she recalled the wound on leg the same day but no information about the leg wound was located on the fax to the provider. LPN-A stated when a skin alteration was found on a resident, a progress note should be made, and the provider should be faxed the information. LPN-A stated the nurses on the floor do not always follow the protocol, herself included. During an interview on 3/26/24 at 9:41 a.m., clinical manager (CM)-A indicated, progress note for R1 identified leg wound on 3/9/24 but provider had not been notified of wound until 3/18/24, although documentation on skin integrity rolling log identified facility acquired on 3/11/24 with measurements of 0.7 cm x 0.8 cm deep tissue injury. CM-A stated, "unfortunately the process for [R1]'s leg wound had not been followed properly." During an interview on 3/25/24 at 3:11 p.m., director of nursing (DON) stated body audits are to be completed on the floor weekly by the nurse assigned to the resident. DON also indicated the	F 580		

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F 580	Continued From page 7 nurse on the floor should be informed of any skin alterations immediately and should then be notifying the DON, the family, and the provider by the end of their shift. The nurse on the floor should be measuring the wounds and describing the wounds in a progress note. DON identified R1's wound found in progress note on 3/9/24 did not have a comprehensive assessment completed on that date, and could not say that the provider had been informed, nor could not recall if she had been informed. DON confirmed, "the wound nurse should have been informed and weekly documentation should then have been initiated." Facility's policy titled, Weekly Skin Assessment and Documentation Process, updated 1/20/23, indicated Skin Ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse. Facility's policy titled, Skin Management Protocol, undated, indicated. All treatment orders included in these protocols requires a physician's signature. Wound Notification Standards a) Notify DON and Wound Nurse of new Skin Alteration or Skin Ulcer. b) Complete Incident Report in Risk Management (Point Click Care) and Skin Sheet (paper). c) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated Weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. e) The community must remove a mechanical lift sling once transfer is completed. Slings may	F 580		

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F 580	Continued From page 8 not be left under a resident at any time when not actively transferring. a) If the Skin Ulcer or Non-Ulcer has not made improvements after the first two weeks, the community must notify the residents physician. Facility policy titled Notification of Change in Resident Health Status, updated 2/8/23, stated: The resident's physician and resident's legal representative will be notified of a change in resident status when the following occur: a) An accident involving the resident which results in injury and has the potential for requiring physician intervention b) A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications c) a need to alter treatment significantly, for example a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		4/26/24

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F 657	Continued From page 9 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise the care plan that addressed goals and interventions for new diagnoses of nonthrombocytopenic pupura for 1 of 1 resident (R2) who developed substantial bruising. Findings include R2's admission record indicated R2 had diagnoses that included chronic pain and other nonthrombocytopenic purpura (purple, red, or yellowish-brown spots or patches develop under the skin due to inflammation, damaged blood vessels, or an underlying health condition). R2's quarterly Minimum Data Set (MDS) dated 2/05/24, identified R2 did not have cognitive impairment, was independent with oral hygiene and eating, and was dependent with toileting, dressing, personal hygiene, and mobility. R2 was	F 657	F 657 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.	

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F 657	Continued From page 10 at risk for pressure ulcers and no other skin problems identified. R2's care plan dated 4/6/23, included R2 has a potential for impairment to skin integrity related to immobility, and incontinence. Interventions included: keep skin clean and dry. Observe skin during cares. Report any changes to nurse. (Care plan did not include risk of bruising and or monitoring.) R2's Weekly Body Audit dated 1/1/24, identified no alterations of skin. Overall summary identified bruising noted throughout at various stages of healing. R2's progress note dated 1/4/24, at 11:36 a.m., directed to add diagnosis of senile purpura (bruising that occurs in the elderly without any major external impact) for easy bruising. R2's Weekly Body Audit dated 1/15/24, resident is bed bound, resting mainly on left side and stomach. She is totally dependent on staff to meet her needs. Lacked any description of skin alterations. R2's progress note dated 1/28/34, at 1:05 p.m., documented nursing assistant (NA) noticed two new bruises on resident left knee and thigh. Nurse called director of nursing (DON). R2's progress note dated 1/29/24, at 10:52 p.m resident due for body audit this shift per treatment administration record (TAR). It is noted that one was performed yesterday. Nurse felt this needed to be done with 2 nurses present as resident had multiple bruises on various areas of body and various stages of healing.	F 657	1. In continuing compliance with F 657, Care Plan Timing and Revision, Green Lea Senior Living corrected the deficiency by reviewing all residents to ensure those with potential for bleeding/bruising have interventions added to their care plan by the MDSC by 04/26/2024. R2 was discharged from the facility on 03/05/2024. 2. To correct the deficiency and to ensure the problem does not recur the MDSC was educated on the Person-Centered Care Plan Guideline by the Director of Nursing by 04/26/2024. The Director of Nursing and/or designee will audit 3 resident care plans for appropriate interventions related to the potential for bleeding/bruising weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process.	

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F 657	Continued From page 11	F 657		

R2's progress note dated 2/4/24, at 1:44 p.m., R2 showed nurse fingertip that blood sugar was drawn on that morning (left hand middle finger), entire fingertip was purple bruised. Measured 2.5 centimeters (cm) x 1.5 cm. R2 stated she was nervous to why she was bruising so easily.

R2's progress note dated 2/14/24, at 4:57 p.m.documented, "hospital transfer related to large hematoma to right upper arm and is going by ambulance to be evaluated in emergency room [ER]." "Resident was having severe bruising lately and labs have not indicated any cause." "Due to new finding, resident agreed to be evaluated further. Nurse called local ambulance to have transported." "Nurse left message for family."" Mass was measured by wound nurse and DON prior to transport. Writer indicated, "R2 left facility at 5:17 p.m."

R2's progress note dated 2/15/24, at 12:31 a.m., writer documented, "R2 returned from ER at 11:44 p.m. via ambulance." "Education provided on hematoma's."

R2's progress note dated 2/23/24, at 10:49 p.m., writer documented, "nurse noticed [R2] was slurring her words and noted left leg was swollen." "Noted that from hip down entire extremity had 3 plus pitting edema."" Behind [R2]'s back of the knee the skin was orange and the rest was yellow." "Nurse recommended resident to go to ER but resident refused. DON and provider notified."

R2's progress note dated 2/24/24, at 9:38 a.m., indicated R2 transferred to the hospital related to noted change in condition with confusion. Left

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F 657	Continued From page 12 lower extremity and posterior knee area swollen, slightly warm, skin yellow in color and pitting edema plus 4. Bruising noted throughout entire body. DON notified. R2's progress note dated 2/24/24 at 4:43 p.m., documented, "call from hospital reported R2 admitted to hospital with hemoglobin low at 5.1 and appears to have internal bleeding." During an interview on 3/26/24, at 3:05 p.m. clinical manager (CM)-A, stated she was the main person for the facility that created the nursing care plans. She had put the diagnoses for nonthrombocytopenic purapura (rash occurs when small blood vessels burst, causing blood to pool under the skin. They appear as small, reddish-purple spots just beneath the skin's surface) in the computer for R2 and had not updated the care plan. CM-A indicated she was responsible for wounds, infection control, Minimum Data Set (MDS) assessments and care plans. CM-A was unable to articulate who was monitoring and or assessing interventions for effectiveness and updating care plans accordingly. CM-A stated, "I guess if I haven't updated the care plans, no interventions were put in." "The new diagnosis for [R2] was put in the computer by me on 1/4/24 in the diagnosis area, I should have put in a care plan for risk for bleeding and bruising." During an interview on 3/26/24, at 3:48 p.m. director of nursing (DON) stated the care plan should be updated as new diagnosis and new interventions are needed for care. DON indicated she was not aware R2's care plans had not been updated and would have expected they would have been. DON indicated she was now aware	F 657		

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F 657	Continued From page 13 the current process for care planning and monitoring interventions for effectiveness was not being done accurately and the facility needed to evaluate and implement a new system for care plans. Facility document titled Person Centered Care Plan revised 10/2017 indicated; COMPREHENSIVE PERSON-CENTERED CARE PLANS: 1. Developed within 7 days after completion of the comprehensive MDS Assessment. Reviewed and revised annually, quarterly, with a significant change in status and as needed. 2. Contain measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being Other Areas to address on the plan of care are: "Skin Integrity Alterations or Risk for: -Pressure reducing mattresses/cushions -Turning/repositioning schedule -Treatments -Wound Clinic Referrals - Podiatry Referrals - Adaptive equipment like Geri-sleeves - Foot boards/heel protectors/wedges - Alternating pressure pads. - Potential for bruising/bleeding (e.g., medications like Coumadin/injections)	F 657		

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete pressure ulcer risk assessment, failed to comprehensively assess and monitor pressure ulcers, notify physician, and follow physician orders to prevent and/or mitigate the risk of new ulcer development or deterioration for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below).	F 686	F 686 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.	4/26/24

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F 686	Continued From page 15 Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. R1's face sheet included diagnoses of chronic right heart failure, acute respiratory failure, type 2 diabetes with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes), type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region (the portion of	F 686	1. In continuing compliance with F 686, Treatment/Svcs to Prevent/Heal Pressure Ulcer, Green Lea Senior Living corrected the deficiency by reviewing all resident Comprehensive Skin and Positioning Evaluations to ensure that those at risk had interventions added to their care plan by MDSC by 04/26/2024. All residents with skin alterations were reviewed to ensure appropriate notification to physician and family/POA by the Director of Nursing and/or designee by 04/26/2024. R1 was discharged from the facility on 04/11/2024. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on the Accura Skin Process, the Notification of Change in Resident Health Status Policy, and following physician orders by the Director of Nursing on 04/26/2024 or prior to their next shift. The Director of Nursing and/or designee will audit 3 residents with skin alterations to ensure the Accura Skin Process and physician treatment orders are being followed weekly x 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 3 resident comprehensive skin and positioning evaluations to ensure those at risk have interventions added to care plan to prevent skin alterations weekly x 12 weeks and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s	

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F 686	Continued From page 16 your spine between your lower back and tailbone) stage 2 non-pressure ulcer of other part of right foot with fat layer exposed. R1's quarterly Minimum Data Set (MDS) dated 3/1/24, indicated R1 had moderate cognitive impairment and was dependent on facility staff for toileting, bathing, dressing, transfers and mobility. R1 was at risk for pressure ulcers, had one unhealed stage 2 pressure ulcer. MDS did not identify any other skin concerns such as other infections of the foot, diabetic foot ulcers, or open lesions on the foot, nor did it identify any other skin concerns present during assessment. Skin treatments included pressure ulcer care, application of ointment/medications other to feet, and application of dressings to feet. R1's care plan revised on 9/20/23, identified R1 had a pressure injury on left buttock, diabetic ulcer on right great toe, injury on left great toe and moisture associated skin damage (MASD.) Interventions included -Administer treatments as ordered and observe for effectiveness, -Encourage off loading every hour and encourage to turn, reposition at least every 2 hours, more often as needed or requested, -notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily cares. Notify family and medical practitioner of any new area of skin breakdown or worsening in status of current area. R1's care plan did not include any revisions to R1's skin condition after 9/20/23. R1's physician orders for skin treatments included the following:	F 686	ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process.	

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F 686	Continued From page 17 -Skin Prep to either heel as needed (PRN) for protection (1/18/23) -Reposition side-to-side in bed every two hours. Waffle cushion when up in recliner or wheelchair (start date 5/25/23) -Skin assessment weekly on Mondays (start date 7/3/2023) -Bilateral (both) buttock cares: wash and dry, apply Calmoseptime (may hold in place with viva towel), only cleanse the soiled top layer off with incontinence, and apply new as needed two times a day (start date 7/10/23) R1's physician assistant visit (PA) dated 2/26/24, indicated R1 had a chronic wound on right foot. PA talked to R1 and family about hospice; with R1's weight loss and respiratory failure and heart failure, "I do expect that he could die within the next 6 months." R1 thought hospice would be a good service for him but he would first like to see the wound clinic to have his foot checked on before officially considering hospice. R1's medical doctor visit note dated 2/27/24, indicated reason for visit was for routine check-up. There has been general deterioration lately and discussion has been started regarding potential hospice placement. Note identified the diabetic ulcer on right foot, family considering hospice admission. The note did not indicate any other areas of impaired skin integrity. Although R1's noted overall decline in condition as documented by physician visits on 2/26/24 and 2/27/24 related to medical diagnosis. R1's record did not include a comprehensive assessment that included tissue tolerance to pressure over bony surfaces and/or evaluation of the appropriateness of R1's care planned pressure alleviating	F 686		

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F 686	Continued From page 18 interventions that had not been revised with new interventions to prevent and/or mitigate the risk of new pressure ulcer development or deterioration since 9/20/23. Weekly Body Audit dated 3/4/24, identified R1 had skin alteration. Alterations that were identified included areas of redness to buttock, no further description on location on buttocks, etiology of redness, measurement of redness, and no treatment plan was included. R1's progress note dated 3/7/24, documented "right heel suspected deep tissue injury 0.5 cm x 0.6 cm dark spot." Facility Skin Integrity log form (form is not in individual resident records) dated 3/2024, identified on 3/7/24, facility identified right heel facility acquired stage 2 caused by pressure . 0.5 cm x 0.6 cm. Treatment was offloading boot. Form indicated care plan was updated, doctor and family notified. A Non-emergent Fax Communication with Provider dated 3/7/24, included R1 has a deep tissue area [right] heel measure 0.5 x 0.6 - Heel protector bootie placed. No open area. The section titled Provider Response was blank. R1's progress note dated 3/9/24, documented registered nurse (RN) and nursing assistant (NA) noted old appearing bandage to left lower leg, lateral aspect, below knee. The bandage was peeling off and had a small amount of dried blood that was now very brown and hardened. Under the bandage was a wound of unknown cause. It had the appearance of possible impact wound and/or pressure injury. It was irregular round area	F 686		

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F 686	Continued From page 19 approximately larger than a quarter. Measurements not obtained at this time. Wound was deep red and purple mix with a dark purple mix with dark brownish center that appears to have been open and now healing over with a new layer of skin. There was no drainage currently. The area appeared to be discolored, raised, hard and not fluid filled resembling a bruise. Possibly area of impact from being bumped. R1 has been quite deconditioned with recent poor health, therefore has not been common for him to leave the bed recently, if at all. R1 insists on keeping several items in the bed with him at all times, along with several remotes. R1 denied pain when area was assessed, there is no indication that R1 typically has prolonged pressure to this outer area of his leg. Director of nursing (DON) notified of injury at this time as RN was unable to find documentation of area. Wound was 1-2 days old. Wound left, dry, and covered with padded bandage to protect. After new skin impairments were identified on 3/4/24 (buttocks), 3/7/24 (right heel-suspected stage 2 pressure ulcer), 3/9/24 (left lateral knee-deep tissue injury) it was not evident weekly comprehensive assessments and ongoing monitoring were completed. R1's Skin Integrity log for the Left lateral knee dated 3/11/24, indicated the wound was facility acquired abrasion Measured 0.7 cm x 0.8 cm. Added to care plan, doctor and family notified. Care plan lacked any documentation related to this wound and indicated had not been updated since 9/20/23. R1's Weekly Body Audit dated 3/11/24, identified R1 had skin alteration. Areas of alterations	F 686		

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F 686	Continued From page 20 included but were not limited to right heal suspected deep tissue injury and lower left lateral leg- skin abrasion. Heels firm with dark spots/discoloration. No further descriptions, measurements of impairments, and no treatment was included. R1's physician assist visit note dated 3/11/24, indicated reason for visit was R1's condition; nurses note an overall decline. R1 was still planning on going to the wound clinic on 3/14/24. He was noted to recently have a small pressure wound on right heel, and pressure offloading boot is now in place on the right heel. Physical exam included: small 1 cm scabbed area on the right lateral heel with pressure-offloading in place on the right heel. The note identified the right foot diabetic ulcer of right foot (toe), pressure injury of right heel stage 2; moderate calorie malnutrition. Nutritional supplements are being given. Continue with wound cares and pressure offloading for the right foot wounds. The wound identified on R1's left lateral knee on 3/9/24 was not addressed in the physician visit note. In review of R1's medical record between 3/9/24 to 3/19/24 did not identify R1's left leg wound was comprehensively assessed, monitored, nor were there any treatments ordered and applied until 3/19/24, 10 days after the PU was identified. R1's Skin integrity log for the right heel dated 3/13/24, identified the stage 2 pressure ulcer measured 0.5 cm x 0.6 cm with no further assessment. R1's Weekly Body Audit dated 3/18/24, no assessment completed	F 686		

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F 686	Continued From page 21 During an interview on 3/25/24 at 12:51 p.m., family member (FM)-A indicated she had come in for a visit around 3/9/24 noted the leg wound when she was putting lotion on R1's legs and he yelled in pain when she got close to the wound that was covered with a bandage with no date on it. FM-A stated she later noted what appeared to be the same bandage in place on the wound a week later, she brought it to the physician's attention on 3/18/24. Physician had lifted the bandage and put the same bandage back on around 8:30 a.m. Physician had ordered the dressing to be completed daily around 3/18/24. However, later the same day R1 was sent to ER in late afternoon around 2:30 p.m. for breathing concerns and returned from the hospital between 8:30p.m. and 9:30 p.m. and the dressing had not been changed. R1's physician assistant (PA) visit dated 3/18/24, indicated R1 decided to cancel wound clinic appointment because he did not have enough stamina to travel the distance. Hospice order was provided. "It was noticed over the last coupe of days that he has a new wound over his left lateral leg. This is presumably from pressure. He has a reacher that he holds himself and keeps in his bed, and his [family member] wonders if perhaps the reacher got underneath him for a period of time and contributed to the pressure." Physical examination included: On the right lateral heel, there is a small area of redness, about 0.5 cm in diameter, non-blanching and the overlying skin appeared to be intact. Left lateral knee there appeared about a 2 cm in diameter with skin breakdown and black necrotic area in the middle with some moist serous drainage on the overlying from dressing. The note indicated PA ordered Arginaid wound protein supplement, "He [R1]	F 686		

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F 686	Continued From page 22 needs repositioning every 2 hours" Additional treatment orders included, continue skin prep daily to the right heel wound with pressure offloading cushion. For the leg wound that is deep tissue injury, "we will trim calcium alginate or Aquacel [non-stick antimicrobial wound dressing] to fit the wound and apply this to the wound bed daily. Cover with bordered foam dressing and change daily. In the future, skin issues can be managed by hospice..." R1's hand written Physician Orders dated 3/18/24 included the following: -Arginaid wound supplement daily -Every two hour repositioning -Continue Skin prep daily to right lateral heel and pressure alleviating cushion -Left lateral knee deep tissue injury: trim calcium alginate (or Aquacel) to fit wound daily and apply over wound bed then cover with bordered foam dressing change daily. Although the physician's ordered R1's skin treatments on 3/18/24, R1's treatment administration record (TAR) identified a start date of 3/19/24 for the "left lateral knee deep tissue injury" treatment and the right lateral heel. There was no indication these treatments were completed on 3/18/24 as ordered. The pressure relief boot on right foot when in bed and in recliner for deep pressure injury to heel had a start date of 3/20/24 even though the reducing intervention was initiated on 3/18/24 as ordered. The record further identified between 3/1/24 to 3/19/24 there was no indication PRN Skin Prep was applied to either of R1's heels for protection (order start date of 1/8/23). R1's progress note dated 3/20/24, documented,	F 686		

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F 686	Continued From page 23 R1 was admitted to hospice on 3/20/24. R1's Skin integrity log for the right heel dated 3/20/24, identified wound increased in size from 0.5 cm x 0.6 cm on 3/13/24 to 0.7 cm x 0.8 cm R1's progress note dated 3/23/24, documented, 3.5 cm x 1.0 cm open area left popliteal area (back part of the leg of the knee joint). No further description of the wound was included. "Wet to dry dressing applied." (Wet to dry dressing was not in accordance with physician order dated 3/18/24). During an observation on 3/25/24 at 1:28 p.m., registered nurse (RN)-A was providing wound cares and noted wound on coccyx area and stated this area was pressure related that was non-blanchable. There was small open areas in the same area that were not measured. Left lower area below the knee had a gauze dressing wrapped around the leg that was not dated. RN-A indicated it was not an expectation the dressing be dated and was not able to articulate how long the wrong dressing according to treatment orders had been on. The gauze was dry and adhered to the wound. RN-A sprayed the gauze with wound cleanser to moisten the gauze and carefully and slowly started unwrapping the dressing. Despite R1 being medicate with narcotic pain medication R1 cried out in pain and displayed facial grimacing as RN-A removed the dressing. The leg wound appeared dark black in color about a quarter or larger with bright red skin surrounding the wound. When RN attempted to touch R1's left leg during wound care R1 again cried out in pain. New dressing was applied at this time as ordered. RN-A noted left heel to be soft and spongy at this time.	F 686		

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	245536	A. BUILDING _____ B. WING _____	C 03/26/2024

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F 686	Continued From page 24 R1's TAR for dates between 3/19/24 to 3/24/24 identified the left lateral knee dressing change was completed according to physician orders except for on 3/22/24, when the recorded entry was "3" indicating R1 refused and on 3/24/24 when the recorded entry was "7" indicating R1 was sleeping. Weekly Body Audit dated 3/25/24, identified R1 had skin alteration on coccyx which was described as reddened but blanchable, skin breakdown beginning, calmoseptime cream applied with brief changes reposition every 2 hours. Lower leg rear (pressure injury 2 centimeters (cm) x 2 cm black eschar tissue. Very painful when touched. Surrounding skin reddened. Dressing changed as ordered. Left heel soft and spongy boot placed at this time. During an interview on 3/26/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated she documented the leg injury for R1 on the 3/11/24 body audit but did not notify the doctor of the injury. LPN-A stated she had faxed the provider about a deep tissue injury on his right heel on 3/7/24 and thought she had provided information about the leg wound on that same fax as she recalled the wound on leg the same day but no information about the leg wound was located on the fax to the provider. LPN-A reported nurses on the floor have not been completing comprehensive skin assessments weekly and she would not consider the document titled, "weekly body audits" as comprehensive skin assessments. LPN-A stated when a skin alteration was found on a resident, a progress note should be made, that included location, description of the wound, measurements,	F 686		

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F 686	Continued From page 25	F 686		

drainage, status and treatments. Then the provider should be faxed the information. LPN-A stated the nurses on the floor do not always follow the protocol, herself included.

During an interview on 3/26/24 at 9:41 a.m., clinical manager (CM)-A reviewed the weekly body audits in conjunction with weekly skin integrity logs and stated they did not always match. CM-A also indicated R1's progress note identified leg wound on 3/9/24, however the skin integrity log identified the leg wound was facility acquired deep tissue injury on 3/11/24, and the physician was not notified of the wound until 3/18/24. CM-A stated, "unfortunately the process for [R1]'s leg wound was not followed properly." CM-A indicated, "body audits were to be completed weekly by nursing staff and they were to inform management of new wounds." CM-A also stated, "the weekly skin audits that had been completed on [R1] would not be considered comprehensive as they did not include skin alteration details, measurements and or locations." Further indicated, there was no description of wound other than measurements noted on the Skin Integrity log forms, and found it difficult to determine healing of wound other than measurements. CM-A stated she recognized the need for better documentation on wounds. Her expectation was nurses on the floor wound know to monitor for infection. CM-A stated she was responsible for updating skin care plans for residents however had not updated R1's care plan with any changes since 2023 even though the Skin Integrity rolling log indicated the care plan had been updated with both the new heel and new leg wound interventions.

During an interview on 3/25/24 at 3:11 p.m.,

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F 686	Continued From page 26 director of nursing (DON) stated body audits were to be completed weekly by the nurse assigned to the resident. DON stated the body audits are comprehensive skin assessments. DON stated if the body audits are not completed in the medical record, she would not be able to determine if they had been completed. DON reported she was unable to locate 5 weekly body assessments in R1's record. DON verified the weekly skin audits that had been completed for R1 did not appear to be comprehensive because skin alterations were identified at times but missing details including wound descriptions, wound measurements, and locations. DON also stated the nurse on the floor should be informed of any skin alterations immediately and should then be notifying the DON, the family, and the provider by the end of their shift. The nurse on the floor should be measuring the wounds and describing the wounds in a progress note. DON stated R1's wound identified in progress note on 3/9/24 did not have a comprehensive assessment completed on that date, could not say that the provider had been informed, and could not recall if she had been informed. The wound care nurse, clinical manager (CM)-A should have been informed and weekly documentation should have than been initiated. DON was unsure if bruising and or rashes are being monitored or assessed as wound nurse only documents on open wounds. DON indicated she was aware that staff education was needed as policy had not been followed for comprehensive skin assessments. Facility's policy titled, Weekly Skin Assessment and Documentation Process, updated 1/20/23, indicated Skin Ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse. Policy did not address	F 686		

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F 686	Continued From page 27 comprehensive skin assessment protocol. Facility's policy titled, Skin Management Protocol, undated, indicated. All treatment orders included in these protocols requires a physician's signature. Wound Notification Standards a) Notify DON and Wound Nurse of new Skin Alteration or Skin Ulcer. b) Complete Incident Report in Risk Management (Point Click Care) and Skin Sheet (paper). c) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated Weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. e) The community must remove a mechanical lift sling once transfer is completed. Slings may not be left under a resident at any time when not actively transferring. a) If the Skin Ulcer or Non-Ulcer has not made improvements after the first two weeks, the community must notify the residents physician.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 2F9N11

Dear Administrator:

The above facility was surveyed on March 25, 2024 through March 26, 2024 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 03/26/2024

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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 3/25/24 and 3/26/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55362260C (MN00101784) with orders issued at 0265 and 0900 H55362300C (MN0010193) with orders issued at 0565 H55362322C (MN00101910) H55362323C (MN00101903) 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	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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to	2 265		4/26/24

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2 265	Continued From page 3 begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure physician notification of skin injury that required treatment for 1 of 3 residents (R1) reviewed for pressure ulcers. The findings include: R1's face sheet printed 3/25/24, included diagnoses of chronic right heart failure, acute respiratory failure, type 2 diabetes mellitus with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes. High blood sugar [glucose] can injure nerves throughout the body.), type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone) stage 2, non-pressure ulcer of other part of right foot with fat layer exposed. R1's quarterly Minimum Data Set (MDS) dated 3/1/24, indicated R1 had moderate cognitive impairment, R1 was at risk for pressure ulcers, had one unhealed stage 2 pressure ulcer (partial thickness loss of dermis [The inner layer of the two main layers of the skin] presenting as a shallow open ulcer with a red or pink wound bed, without slough. May present as an intact or open/ruptured serum filled blister.) MDS did not identify any other skin concerns such as other	2 265	Corrected	

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2 265	Continued From page 4 infections of the foot, diabetic foot ulcers, or open lesions on the foot, nor did it identify any other skin concerns present during assessment. Skin treatments included pressure ulcer care, application of ointment/medications other to feet, and application of dressings to feet. R1's care plan revised on 9/20/23, identified R1 had a pressure injury on left buttock, diabetic ulcer on right great toe, injury on left great toe and moisture associated skin damage (MASD.). R1's progress note dated 3/9/24, documented registered nurse (RN) and nursing assistant (NA) noted old appearing bandage to left lower leg, lateral aspect, below knee. The bandage was peeling off and had a small amount of dried blood that was now very brown and hardened. Under the bandage was a wound of unknown cause. It had the appearance of possible impact wound and/or pressure injury. It was irregular round area approximately larger than a quarter. Measurements not obtained at this time. Wound was deep red and purple mix with a dark purple mix with dark brownish center that appears to have been open and now healing over with a new layer of skin. There was no drainage currently. The area appeared to be discolored and quite raised, hard and not fluid filled. More so resembled a bruise. Possibly area of impact from being bumped. R1 has been quite deconditioned with recent poor health, therefore has not been common for him to leave the bed recently, if at all. R1 insists on keeping several items in the bed with him at all times, along with several remotes. R1 denied pain when area was assessed. It does not appear R1 typically has prolonged pressure to this outer area of his leg. Director of nursing [DON] noted to be notified of injury at this time as RN was unable to find documentation of area.	2 265		

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2 265	Continued From page 5 Wound appeared to be 1-2 days old. Wound left dry and covered with padded bandage to protect. R1's Skin Integrity log for the Left lateral knee dated 3/11/24, indicated the wound was facility acquired abrasion Measured 0.7 cm x 0.8 cm. Added to care plan, doctor and family notified. In review of R1's record between 3/9/24 to 3/18/24, it was not evident the physician was notified of R1's left lateral knee wound. Additionally, there was no indication of a physician ordered treatment in that time frame. During an interview on 3/25/24 at 12:51 p.m., family member (FM)-A indicated she had come in for a visit around 3/9/24 noted the leg wound when she was putting lotion on R1's legs and he yelled in pain when she got close to the wound that was covered with a bandage with no date on it. FM-A stated she later noted what appeared to be the same bandage in place on the wound a week later, she brought it to the physician's attention on 3/18/24. Physician had lifted the bandage and put the same bandage back on around 8:30 a.m., physician gave an order for the dressing to be completed daily around 3/18/24. However, later the same day R1 was sent to ER in late afternoon around 2:30 p.m. for breathing concerns and returned from the hospital between 8:30p.m. and 9:30 p.m. and dressing had not been changed. R1's physician assistant (PA) visit dated 3/18/24, included "It was noticed over the last coupe of days that he has a new wound over his left lateral leg. This is presumably from pressure. He has a reacher that he holds himself and keeps in his bed, and his [family member] wonders if perhaps the reacher got underneath him for a period of	2 265		

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2 265	Continued From page 6	2 265		

time and contributed to the pressure." Physical examination included: On the right lateral heel, there is a small area of redness, about 0.5 cm in diameter, non-blanching and the overlying skin appeared to be intact. Left lateral knee there appeared about a 2 cm in diameter with skin breakdown and black necrotic area in the middle with some moist serous drainage on the overlying from dressing. The note indicated PA ordered Arginaid wound protein supplement, "He [R1] needs repositioning every 2 hours" Additional treatment orders included, continue skin prep daily to the right heel wound with pressure offloading cushion. For the leg wound that is deep tissue injury, "we will trim calcium alginate or Aquacel [non-stick antimicrobial wound dressing] to fit the wound and apply this to the wound bed daily. Cover with bordered foam dressing and change daily.

R1's March 2024 treatment administration record (TAR) identified the aforementioned treatment plan that was identified in the physician note; the knee dressing identified a start date of 3/19/24.

During an observation on 3/25/24 at 1:28 p.m., registered nurse (RN)-A was providing wound cares. Left lower area below the knee had a gauze dressing wrapped around the leg that was not dated. RN-A indicated it was not an expectation the dressing be dated and was not able to articulate how long the wrong dressing according to treatment orders had been on. The gauze was dry and adhered to the wound. RN-A sprayed the gauze with wound cleanser to moisten the gauze and carefully and slowly started unwrapping the dressing. Despite R1 being medicated with narcotic pain medication R1 cried out in pain and displayed facial grimacing as RN-A removed the dressing. The leg wound

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	00124	A. BUILDING: _____ B. WING _____	C 03/26/2024

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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) COMPLETE DATE
2 265	Continued From page 7 appeared dark black in color about a quarter or larger with bright red skin surrounding the wound. When RN attempted to touch R1's left leg during wound care R1 again cried out in pain. New dressing was applied at this time as ordered. RN-A noted left heal to be soft and spongy at this time. During an interview on 3/26/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated she documented the leg injury for R1 on the 3/11/24 body audit but did not notify the doctor of the injury. LPN-A stated she had faxed the provider about a deep tissue injury on his right heel on 3/7/24 and thought she had provided information about the leg wound on that same fax as she recalled the wound on leg the same day but no information about the leg wound was located on the fax to the provider. LPN-A stated when a skin alteration was found on a resident, a progress note should be made, and the provider should be faxed the information. LPN-A stated the nurses on the floor do not always follow the protocol, herself included. During an interview on 3/26/24 at 9:41 a.m., clinical manager (CM)-A indicated, progress note for R1 identified leg wound on 3/9/24 but provider had not been notified of wound until 3/18/24, although documentation on skin integrity rolling log identified facility acquired on 3/11/24 with measurements of 0.7 cm x 0.8 cm deep tissue injury. CM-A stated, "unfortunately the process for [R1]'s leg wound had not been followed properly." During an interview on 3/25/24 at 3:11 p.m., director of nursing (DON) stated body audits are to be completed on the floor weekly by the nurse assigned to the resident. DON also indicated the	2 265		

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2 265	Continued From page 8 nurse on the floor should be informed of any skin alterations immediately and should then be notifying the DON, the family, and the provider by the end of their shift. The nurse on the floor should be measuring the wounds and describing the wounds in a progress note. DON identified R1's wound found in progress note on 3/9/24 did not have a comprehensive assessment completed on that date, and could not say that the provider had been informed, nor could not recall if she had been informed. DON confirmed, "the wound nurse should have been informed and weekly documentation should then have been initiated." Facility's policy titled, Weekly Skin Assessment and Documentation Process, updated 1/20/23, indicated Skin Ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse. Facility's policy titled, Skin Management Protocol, undated, indicated. All treatment orders included in these protocols requires a physician's signature. Wound Notification Standards a) Notify DON and Wound Nurse of new Skin Alteration or Skin Ulcer. b) Complete Incident Report in Risk Management (Point Click Care) and Skin Sheet (paper). c) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated Weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. e) The community must remove a mechanical lift sling once transfer is completed. Slings may not be left under a resident at any time when not	2 265		

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2 265	Continued From page 9 actively transferring. a) If the Skin Ulcer or Non-Ulcer has not made improvements after the first two weeks, the community must notify the residents physician. Facility policy titled Notification of Change in Resident Health Status, updated 2/8/23, stated: The resident's physician and resident's legal representative will be notified of a change in resident status when the following occur: a) An accident involving the resident which results in injury and has the potential for requiring physician intervention b) A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications c) a need to alter treatment significantly, for example a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples on when the physician should be notified. The DON or designee could perform audits of medical records to determine if the physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		4/26/24

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2 565	Continued From page 10 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to revise the care plan that addressed goals and interventions for new diagnoses of nonthrombocytopenic pupura for 1 of 1 resident (R2) who developed substantial bruising. Findings include R2's admission record indicated R2 had diagnoses that included chronic pain and other nonthrombocytopenic purpura (purple, red, or yellowish-brown spots or patches develop under the skin due to inflammation, damaged blood vessels, or an underlying health condition). R2's quarterly Minimum Data Set (MDS) dated 2/05/24, identified R2 did not have cognitive impairment, was independent with oral hygiene and eating, and was dependent with toileting, dressing, personal hygiene, and mobility. R2 was at risk for pressure ulcers and no other skin problems identified. R2's care plan dated 4/6/23, included R2 has a potential for impairment to skin integrity related to immobility, and incontinence. Interventions included: keep skin clean and dry. Observe skin during cares. Report any changes to nurse. (Care plan did not include risk of bruising and or	2 565	Corrected.	

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2 565	Continued From page 11 monitoring.) R2's Weekly Body Audit dated 1/1/24, identified no alterations of skin. Overall summary identified bruising noted throughout at various stages of healing. R2's progress note dated 1/4/24, at 11:36 a.m., directed to add diagnosis of senile purpura (bruising that occurs in the elderly without any major external impact) for easy bruising. R2's Weekly Body Audit dated 1/15/24, resident is bed bound, resting mainly on left side and stomach. She is totally dependent on staff to meet her needs. Lacked any description of skin alterations. R2's progress note dated 1/28/34, at 1:05 p.m., documented nursing assistant (NA) noticed two new bruises on resident left knee and thigh. Nurse called director of nursing (DON). R2's progress note dated 1/29/24, at 10:52 p.m resident due for body audit this shift per treatment administration record (TAR). It is noted that one was performed yesterday. Nurse felt this needed to be done with 2 nurses present as resident had multiple bruises on various areas of body and various stages of healing. R2's progress note dated 2/4/24, at 1:44 p.m., R2 showed nurse fingertip that blood sugar was drawn on that morning (left hand middle finger), entire fingertip was purple bruised. Measured 2.5 centimeters (cm) x 1.5 cm. R2 stated she was nervous to why she was bruising so easily. R2's progress note dated 2/14/24, at 4:57 p.m.documented, "hospital transfer related to	2 565		

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2 565	Continued From page 12 large hematoma to right upper arm and is going by ambulance to be evaluated in emergency room [ER]." "Resident was having severe bruising lately and labs have not indicated any cause." "Due to new finding, resident agreed to be evaluated further. Nurse called local ambulance to have transported." "Nurse left message for family."" Mass was measured by wound nurse and DON prior to transport. Writer indicated, "R2 left facility at 5:17 p.m." R2's progress note dated 2/15/24, at 12:31 a.m., writer documented, "R2 returned from ER at 11:44 p.m. via ambulance." "Education provided on hematoma's." R2's progress note dated 2/23/24, at 10:49 p.m., writer documented, "nurse noticed [R2] was slurring her words and noted left leg was swollen." "Noted that from hip down entire extremity had 3 plus pitting edema."" Behind [R2]'s back of the knee the skin was orange and the rest was yellow." "Nurse recommended resident to go to ER but resident refused. DON and provider notified." R2's progress note dated 2/24/24, at 9:38 a.m., indicated R2 transferred to the hospital related to noted change in condition with confusion. Left lower extremity and posterior knee area swollen, slightly warm, skin yellow in color and pitting edema plus 4. Bruising noted throughout entire body. DON notified. R2's progress note dated 2/24/24 at 4:43 p.m., documented, "call from hospital reported R2 admitted to hospital with hemoglobin low at 5.1 and appears to have internal bleeding." During an interview on 3/26/24, at 3:05 p.m.	2 565		

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2 565	Continued From page 13 clinical manager (CM)-A, stated she was the main person for the facility that created the nursing care plans. She had put the diagnoses for nonthrombocytopenic purapura (rash occurs when small blood vessels burst, causing blood to pool under the skin. They appear as small, reddish-purple spots just beneath the skin's surface) in the computer for R2 and had not updated the care plan. CM-A indicated she was responsible for wounds, infection control, Minimum Data Set (MDS) assessments and care plans. CM-A was unable to articulate who was monitoring and or assessing interventions for effectiveness and updating care plans accordingly. CM-A stated, "I guess if I haven't updated the care plans, no interventions were put in." "The new diagnosis for [R2] was put in the computer by me on 1/4/24 in the diagnosis area, I should have put in a care plan for risk for bleeding and bruising." During an interview on 3/26/24, at 3:48 p.m. director of nursing (DON) stated the care plan should be updated as new diagnosis and new interventions are needed for care. DON indicated she was not aware R2's care plans had not been updated and would have expected they would have been. DON indicated she was now aware the current process for care planning and monitoring interventions for effectiveness was not being done accurately and the facility needed to evaluate and implement a new system for care plans. Facility document titled Person Centered Care Plan revised 10/2017 indicated; COMPREHENSIVE PERSON-CENTERED CARE PLANS: 1. Developed within 7 days after completion of the	2 565		

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2 565	Continued From page 14 comprehensive MDS Assessment. Reviewed and revised annually, quarterly, with a significant change in status and as needed. 2. Contain measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being Other Areas to address on the plan of care are: "Skin Integrity Alterations or Risk for: -Pressure reducing mattresses/cushions -Turning/repositioning schedule -Treatments -Wound Clinic Referrals - Podiatry Referrals - Adaptive equipment like Geri-sleeves - Foot boards/heel protectors/wedges - Alternating pressure pads. - Potential for bruising/bleeding (e.g., medications like Coumadin/injections) SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine	2 565		

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2 565	Continued From page 15 compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete pressure ulcer risk assessment, failed to comprehensively assess and monitor pressure ulcers, notify physician, and follow physician orders to prevent and/or mitigate the risk of new ulcer development or deterioration for 1 of 3 residents (R1) reviewed for pressure ulcers.	2 900	Corrected.	4/26/24

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2 900	Continued From page 16 Findings include: Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and	2 900		

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2 900	Continued From page 17 discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. R1's face sheet included diagnoses of chronic right heart failure, acute respiratory failure, type 2 diabetes with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes), type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone) stage 2 non-pressure ulcer of other part of right foot with fat layer exposed. R1's quarterly Minimum Data Set (MDS) dated 3/1/24, indicated R1 had moderate cognitive impairment and was dependent on facility staff for toileting, bathing, dressing, transfers and mobility. R1 was at risk for pressure ulcers, had one unhealed stage 2 pressure ulcer. MDS did not identify any other skin concerns such as other infections of the foot, diabetic foot ulcers, or open lesions on the foot, nor did it identify any other skin concerns present during assessment. Skin treatments included pressure ulcer care, application of ointment/medications other to feet, and application of dressings to feet. R1's care plan revised on 9/20/23, identified R1 had a pressure injury on left buttock, diabetic ulcer on right great toe, injury on left great toe and moisture associated skin damage (MASD.) Interventions included -Administer treatments as ordered and observe for effectiveness, -Encourage off loading every hour and encourage to turn, reposition at least every 2 hours, more often as needed or requested, -notify nurse immediately of any new areas of	2 900		

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2 900	Continued From page 18 skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily cares. Notify family and medical practitioner of any new area of skin breakdown or worsening in status of current area. R1's care plan did not include any revisions to R1's skin condition after 9/20/23. R1's physician orders for skin treatments included the following: -Skin Prep to either heel as needed (PRN) for protection (1/18/23) -Reposition side-to-side in bed every two hours. Waffle cushion when up in recliner or wheelchair (start date 5/25/23) -Skin assessment weekly on Mondays (start date 7/3/2023) -Bilateral (both) buttock cares: wash and dry, apply Calmoseptime (may hold in place with viva towel), only cleanse the soiled top layer off with incontinence, and apply new as needed two times a day (start date 7/10/23) R1's physician assistant visit (PA) dated 2/26/24, indicated R1 had a chronic wound on right foot. PA talked to R1 and family about hospice; with R1's weight loss and respiratory failure and heart failure, "I do expect that he could die within the next 6 months." R1 thought hospice would be a good service for him but he would first like to see the wound clinic to have his foot checked on before officially considering hospice. R1's medical doctor visit note dated 2/27/24, indicated reason for visit was for routine check-up. There has been general deterioration lately and discussion has been started regarding potential hospice placement. Note identified the diabetic ulcer on right foot, family considering hospice admission. The note did not indicate any	2 900		

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2 900	Continued From page 19 other areas of impaired skin integrity. Although R1's noted overall decline in condition as documented by physician visits on 2/26/24 and 2/27/24 related to medical diagnosis. R1's record did not include a comprehensive assessment that included tissue tolerance to pressure over bony surfaces and/or evaluation of the appropriateness of R1's care planned pressure alleviating interventions that had not been revised with new interventions to prevent and/or mitigate the risk of new pressure ulcer development or deterioration since 9/20/23. Weekly Body Audit dated 3/4/24, identified R1 had skin alteration. Alterations that were identified included areas of redness to buttock, no further description on location on buttocks, etiology of redness, measurement of redness, and no treatment plan was included. R1's progress note dated 3/7/24, documented "right heel suspected deep tissue injury 0.5 cm x 0.6 cm dark spot." Facility Skin Integrity log form (form is not in individual resident records) dated 3/2024, identified on 3/7/24, facility identified right heel facility acquired stage 2 caused by pressure . 0.5 cm x 0.6 cm. Treatment was offloading boot. Form indicated care plan was updated, doctor and family notified. A Non-emergent Fax Communication with Provider dated 3/7/24, included R1 has a deep tissue area [right] heel measure 0.5 x 0.6 - Heel protector bootie placed. No open area. The section titled Provider Response was blank. R1's progress note dated 3/9/24, documented	2 900		

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2 900	Continued From page 20 registered nurse (RN) and nursing assistant (NA) noted old appearing bandage to left lower leg, lateral aspect, below knee. The bandage was peeling off and had a small amount of dried blood that was now very brown and hardened. Under the bandage was a wound of unknown cause. It had the appearance of possible impact wound and/or pressure injury. It was irregular round area approximately larger than a quarter. Measurements not obtained at this time. Wound was deep red and purple mix with a dark purple mix with dark brownish center that appears to have been open and now healing over with a new layer of skin. There was no drainage currently. The area appeared to be discolored, raised, hard and not fluid filled resembling a bruise. Possibly area of impact from being bumped. R1 has been quite deconditioned with recent poor health, therefore has not been common for him to leave the bed recently, if at all. R1 insists on keeping several items in the bed with him at all times, along with several remotes. R1 denied pain when area was assessed, there is no indication that R1 typically has prolonged pressure to this outer area of his leg. Director of nursing (DON) notified of injury at this time as RN was unable to find documentation of area. Wound was 1-2 days old. Wound left, dry, and covered with padded bandage to protect. After new skin impairments were identified on 3/4/24 (buttocks), 3/7/24 (right heel-suspected stage 2 pressure ulcer), 3/9/24 (left lateral knee-deep tissue injury) it was not evident weekly comprehensive assessments and ongoing monitoring were completed. R1's Skin Integrity log for the Left lateral knee dated 3/11/24, indicated the wound was facility acquired abrasion Measured 0.7 cm x 0.8 cm.	2 900		

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2 900	Continued From page 21 Added to care plan, doctor and family notified. Care plan lacked any documentation related to this wound and indicated had not been updated since 9/20/23. R1's Weekly Body Audit dated 3/11/24, identified R1 had skin alteration. Areas of alterations included but were not limited to right heal suspected deep tissue injury and lower left lateral leg- skin abrasion. Heels firm with dark spots/discoloration. No further descriptions, measurements of impairments, and no treatment was included. R1's physician assist visit note dated 3/11/24, indicated reason for visit was R1's condition; nurses note an overall decline. R1 was still planning on going to the wound clinic on 3/14/24. He was noted to recently have a small pressure wound on right heel, and pressure offloading boot is now in place on the right heel. Physical exam included: small 1 cm scabbed area on the right lateral heel with pressure-offloading in place on the right heel. The note identified the right foot diabetic ulcer of right foot (toe), pressure injury of right heel stage 2; moderate calorie malnutrition. Nutritional supplements are being given. Continue with wound cares and pressure offloading for the right foot wounds. The wound identified on R1's left lateral knee on 3/9/24 was not addressed in the physician visit note. In review of R1's medical record between 3/9/24 to 3/19/24 did not identify R1's left leg wound was comprehensively assessed, monitored, nor were there any treatments ordered and applied until 3/19/24, 10 days after the PU was identified. R1's Skin integrity log for the right heel dated 3/13/24, identified the stage 2 pressure ulcer	2 900		

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2 900	Continued From page 22 measured 0.5 cm x 0.6 cm with no further assessment. R1's Weekly Body Audit dated 3/18/24, no assessment completed During an interview on 3/25/24 at 12:51 p.m., family member (FM)-A indicated she had come in for a visit around 3/9/24 noted the leg wound when she was putting lotion on R1's legs and he yelled in pain when she got close to the wound that was covered with a bandage with no date on it. FM-A stated she later noted what appeared to be the same bandage in place on the wound a week later, she brought it to the physician's attention on 3/18/24. Physician had lifted the bandage and put the same bandage back on around 8:30 a.m. Physician had ordered the dressing to be completed daily around 3/18/24. However, later the same day R1 was sent to ER in late afternoon around 2:30 p.m. for breathing concerns and returned from the hospital between 8:30p.m. and 9:30 p.m. and the dressing had not been changed. R1's physician assistant (PA) visit dated 3/18/24, indicated R1 decided to cancel wound clinic appointment because he did not have enough stamina to travel the distance. Hospice order was provided. "It was noticed over the last coupe of days that he has a new wound over his left lateral leg. This is presumably from pressure. He has a reacher that he holds himself and keeps in his bed, and his [family member] wonders if perhaps the reacher got underneath him for a period of time and contributed to the pressure." Physical examination included: On the right lateral heel, there is a small area of redness, about 0.5 cm in diameter, non-blanching and the overlying skin appeared to be intact. Left lateral knee there	2 900		

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2 900	Continued From page 23 appeared about a 2 cm in diameter with skin breakdown and black necrotic area in the middle with some moist serous drainage on the overlying from dressing. The note indicated PA ordered Arginaid wound protein supplement, "He [R1] needs repositioning every 2 hours" Additional treatment orders included, continue skin prep daily to the right heel wound with pressure offloading cushion. For the leg wound that is deep tissue injury, "we will trim calcium alginate or Aquacel [non-stick antimicrobial wound dressing] to fit the wound and apply this to the wound bed daily. Cover with bordered foam dressing and change daily. In the future, skin issues can be managed by hospice..." R1's hand written Physician Orders dated 3/18/24 included the following: -Arginaid wound supplement daily -Every two hour repositioning -Continue Skin prep daily to right lateral heel and pressure alleviating cushion -Left lateral knee deep tissue injury: trim calcium alginate (or Aquacel) to fit wound daily and apply over wound bed then cover with bordered foam dressing change daily. Although the physician's ordered R1's skin treatments on 3/18/24, R1's treatment administration record (TAR) identified a start date of 3/19/24 for the "left lateral knee deep tissue injury" treatment and the right lateral heel. There was no indication these treatments were completed on 3/18/24 as ordered. The pressure relief boot on right foot when in bed and in recliner for deep pressure injury to heel had a start date of 3/20/24 even though the reducing intervention was initiated on 3/18/24 as ordered. The record further identified between 3/1/24 to 3/19/24 there was no indication PRN Skin Prep	2 900		

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2 900	Continued From page 24 was applied to either of R1's heels for protection (order start date of 1/8/23). R1's progress note dated 3/20/24, documented, R1 was admitted to hospice on 3/20/24. R1's Skin integrity log for the right heel dated 3/20/24, identified wound increased in size from 0.5 cm x 0.6 cm on 3/13/24 to 0.7 cm x 0.8 cm R1's progress note dated 3/23/24, documented, 3.5 cm x 1.0 cm open area left popliteal area (back part of the leg of the knee joint). No further description of the wound was included. "Wet to dry dressing applied." (Wet to dry dressing was not in accordance with physician order dated 3/18/24). During an observation on 3/25/24 at 1:28 p.m., registered nurse (RN)-A was providing wound cares and noted wound on coccyx area and stated this area was pressure related that was non-blanchable. There was small open areas in the same area that were not measured. Left lower area below the knee had a gauze dressing wrapped around the leg that was not dated. RN-A indicated it was not an expectation the dressing be dated and was not able to articulate how long the wrong dressing according to treatment orders had been on. The gauze was dry and adhered to the wound. RN-A sprayed the gauze with wound cleanser to moisten the gauze and carefully and slowly started unwrapping the dressing. Despite R1 being medicate with narcotic pain medication R1 cried out in pain and displayed facial grimacing as RN-A removed the dressing. The leg wound appeared dark black in color about a quarter or larger with bright red skin surrounding the wound. When RN attempted to touch R1's left leg during wound care R1 again cried out in pain.	2 900		

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2 900	Continued From page 25 New dressing was applied at this time as ordered. RN-A noted left heel to be soft and spongy at this time. R1's TAR for dates between 3/19/24 to 3/24/24 identified the left lateral knee dressing change was completed according to physician orders except for on 3/22/24, when the recorded entry was "3" indicating R1 refused and on 3/24/24 when the recorded entry was "7" indicating R1 was sleeping. Weekly Body Audit dated 3/25/24, identified R1 had skin alteration on coccyx which was described as reddened but blanchable, skin breakdown beginning, calmoseptime cream applied with brief changes reposition every 2 hours. Lower leg rear (pressure injury 2 centimeters (cm) x 2 cm black eschar tissue. Very painful when touched. Surrounding skin reddened. Dressing changed as ordered. Left heel soft and spongy boot placed at this time. During an interview on 3/26/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated she documented the leg injury for R1 on the 3/11/24 body audit but did not notify the doctor of the injury. LPN-A stated she had faxed the provider about a deep tissue injury on his right heel on 3/7/24 and thought she had provided information about the leg wound on that same fax as she recalled the wound on leg the same day but no information about the leg wound was located on the fax to the provider. LPN-A reported nurses on the floor have not been completing comprehensive skin assessments weekly and she would not consider the document titled, "weekly body audits" as comprehensive skin assessments. LPN-A stated when a skin alteration was found on a resident, a progress	2 900		

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2 900	Continued From page 26 note should be made, that included location, description of the wound, measurements, drainage, status and treatments. Then the provider should be faxed the information. LPN-A stated the nurses on the floor do not always follow the protocol, herself included. During an interview on 3/26/24 at 9:41 a.m., clinical manager (CM)-A reviewed the weekly body audits in conjunction with weekly skin integrity logs and stated they did not always match. CM-A also indicated R1's progress note identified leg wound on 3/9/24, however the skin integrity log identified the leg wound was facility acquired deep tissue injury on 3/11/24, and the physician was not notified of the wound until 3/18/24. CM-A stated, "unfortunately the process for [R1]'s leg wound was not followed properly." CM-A indicated, "body audits were to be completed weekly by nursing staff and they were to inform management of new wounds." CM-A also stated, "the weekly skin audits that had been completed on [R1] would not be considered comprehensive as they did not include skin alteration details, measurements and or locations." Further indicated, there was no description of wound other than measurements noted on the Skin Integrity log forms, and found it difficult to determine healing of wound other than measurements. CM-A stated she recognized the need for better documentation on wounds. Her expectation was nurses on the floor wound know to monitor for infection. CM-A stated she was responsible for updating skin care plans for residents however had not updated R1's care plan with any changes since 2023 even though the Skin Integrity rolling log indicated the care plan had been updated with both the new heel and new leg wound interventions.	2 900		

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2 900	Continued From page 27 During an interview on 3/25/24 at 3:11 p.m., director of nursing (DON) stated body audits were to be completed weekly by the nurse assigned to the resident. DON stated the body audits are comprehensive skin assessments. DON stated if the body audits are not completed in the medical record, she would not be able to determine if they had been completed. DON reported she was unable to locate 5 weekly body assessments in R1's record. DON verified the weekly skin audits that had been completed for R1 did not appear to be comprehensive because skin alterations were identified at times but missing details including wound descriptions, wound measurements, and locations. DON also stated the nurse on the floor should be informed of any skin alterations immediately and should then be notifying the DON, the family, and the provider by the end of their shift. The nurse on the floor should be measuring the wounds and describing the wounds in a progress note. DON stated R1's wound identified in progress note on 3/9/24 did not have a comprehensive assessment completed on that date, could not say that the provider had been informed, and could not recall if she had been informed. The wound care nurse, clinical manager (CM)-A should have been informed and weekly documentation should have than been initiated. DON was unsure if bruising and or rashes are being monitored or assessed as wound nurse only documents on open wounds. DON indicated she was aware that staff education was needed as policy had not been followed for comprehensive skin assessments. Facility's policy titled, Weekly Skin Assessment and Documentation Process, updated 1/20/23, indicated Skin Ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse. Policy did not address	2 900		

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2 900	Continued From page 28 comprehensive skin assessment protocol. Facility's policy titled, Skin Management Protocol, undated, indicated. All treatment orders included in these protocols requires a physician's signature. Wound Notification Standards a) Notify DON and Wound Nurse of new Skin Alteration or Skin Ulcer. b) Complete Incident Report in Risk Management (Point Click Care) and Skin Sheet (paper). c) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated Weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. e) The community must remove a mechanical lift sling once transfer is completed. Slings may not be left under a resident at any time when not actively transferring. a) If the Skin Ulcer or Non-Ulcer has not made improvements after the first two weeks, the community must notify the residents physician. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The	2 900		

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2 900	Continued From page 29 DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		