



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 16, 2025

Administrator

Green Lea Senior Living

115 NORTH LYNDAL, RR 2 BOX 49

MABEL, MN 55954

RE: CCN: 245536

Cycle Start Date: October 17, 2025

Dear Administrator:

On November 4, 2025, we notified you a remedy was imposed.

On November 21, 2025, the Minnesota Department of Health 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 November 15, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 19, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of November 4, 2025, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 17, 2025. 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,

A handwritten signature in blue ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us



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December 16, 2025

Administrator

Green Lea Senior Living

115 NORTH LYNDAL, RR 2 BOX 49

MABEL, MN 55954

Re: Reinspection Results

Event ID: 1D91A2-H2

Dear Administrator:

On November 21, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 17, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
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St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

November 4, 2025

Administrator

Green Lea Senior Living

115 North Lyndale, Rr 2 Box 49

Mabel, MN 55954

RE: CCN: 824025600

Cycle Start Date: October 17, 2025

Dear Administrator:

On October 17, 2025, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 17, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 19, 2025.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 19, 2025 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 19, 2025 (42 CFR 488.417 (b)).

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.

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 \$13,343; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 17, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. *Therefore, Green Lea Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 17, 2025.* This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R.

968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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; and
- How the facility will identify other residents having the potential to be affected by the same deficient practice; and
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; and
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected; and
- 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 "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 April 17, 2026, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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:

tamika.brown@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 Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3B 3rd Floor
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/17/2025	
NAME OF PROVIDER OR SUPPLIER Green Lea Senior Living				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDALDE, RR 2 BOX 49 , MABEL, Minnesota, 55954			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS On 10/10/25, 10/14/25, 10/15/25, 10/16/25, and 10/17/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 9/30/25 after R1's third fall with no completion of a causal analysis or implementation of fall interventions which resulted in and/or could have mitigated the risk of R1's fall on 10/3/25 fall with major injury that required 5-day hospitalization and two subsequent falls on 10/8/25 upon readmission to the facility. The administrator, and director of nursing (DON) were notified of the IJ on 10/14/25 at 5:31 p.m. The IJ was removed on 10/17/25 at 2:50 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 10/16/25 and 10/17/25. The following complaints were reviewed: H55365623C (2638150) with a deficiency cited at F558, F609, F641, F655, F689, F690, F839, F867, and F880 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.		F0000			11/05/2025	
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)		F0558	F558 R2 call light cord was immediately placed within reach upon identification of the deficiency. R2 call light		11/15/2025	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/17/2025
NAME OF PROVIDER OR SUPPLIER Green Lea Senior Living			STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDAL, RR 2 BOX 49 , MABEL, Minnesota, 55954	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0558 SS = D	Continued from page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure call lights were accessible and within reach for 2 of 3 residents (R2 and R5) reviewed for falls Findings include: R2's face sheet dated 10/16/25, identified diagnoses of Parkinson's disease (a progressive brain disorder that affects movement, causing symptoms like tremors, stiffness, and slowed movements) and dementia (a decline in memory, thinking, reasoning and problem solving). R2's Minimum Data Set (MDS) dated 7/16/25, identified R2 had severe cognitive impairment, needed extensive assistance for all transfers. R2's fall focus care plan identified R2 was at risk for falls related to poor balance and unaware of safety risks. Intervention of call light to be within reach. During and observation and interview on 10/10/25 at 4:05 p.m., R2 was sitting in his room in his wheelchair with a tray table in front of him. R2 asked for surveyor to come into his room, there was a drinking cup on the floor to R2's left side. R2 asked surveyor to pick up his glass for him. R2's call light was sitting on the floor in front of the recliner about two feet behind R2. R2 stated he did not have "my button". Nursing assistant (NA)-A entered R2's room at 4:10 p.m. NA-A identified R2's call light should have been placed within R2's reach because he tended to get agitated and may try to self-transfer if the call light is not accessible. R5's face sheet dated 10/16/25, identified diagnosis of Alzheimer's Disease (a progressive brain disorder characterized by gradual decline in memory, thinking, and language skills). R5's Minimum Data Set dated 8/20/25, identified R5 had severe cognitive impairment and needed maximum assistance for transfers. R5's fall focus care plan identified R5 was at risk for falls related to limited physical mobility. Interventions included to have call light within reach. During an observation and interview on 10/14/25 at 3:58 p.m., R5 was sitting in a recliner in her room and had requested the surveyor to come into her room to pick of her cup and chocolate pieces that were located on the floor next to her feet. R5 explained she could not find her "button". Her call light was on the floor next to her left foot, not within in reach. NA-F entered R5's	F0558	Continued from page 1 cord was inspected to ensure it had a clip on the cord, so staff can secure the call light within reach of the resident. R5 passed away on 10/23/2025. Policy and procedure, Call Lights: Accessibility and Timely Response, was reviewed and updated on 11/6/25. The policy was updated to reflect the clip on the call light cord, to secure the call light within reach of the resident. A comprehensive audit was conducted on all residents' rooms to ensure call lights were accessible and within reach. The audit included ensuring all residents' call lights had a clip on the cord, so staff have the ability to secure the call light within reach of the resident to avoid it falling out of reach. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All staff will be educated on facility policy, Call Lights: Accessibility and Timely Response, prior to our compliance date. Education on the policy was initiated on 11/7/25. Education included: ensuring residents have a call light within reach and secured for access at all times, at resident bedside, toilet, and bathing facility. On-call staff who have not been scheduled to work prior to our compliance date will be completed prior to their next scheduled shift. 2) 10 random residents will be audited weekly for 3 months to ensure the residents have their call light accessible per policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of Completion: November 15, 2025	

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(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
F0558 SS = D	Continued from page 2 room at 4:06 p.m. NA-F stated R5's call light was not within reach and should have been placed where R5 could reach it so she could ask for help. During an interview on 10/17/25 at 3:05 p.m., director of nursing (DON) stated all residents should always have call lights within reach and her expectation would be for all staff to ensure the call lights are place appropriately. Review of the facility's Call Light: Accessibility and Timely Response Policy undated, identified /the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. /Policy Explanation and Compliance Guidelines included: /Staff will ensure the call light is within reach of resident and secured, as needed.	F0558		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0609	F 609 Reporting of Alleged Violations Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Education provided to Administrator and DON of reporting requirements. Administrator and/or DON will contact RN Consultant and/or Administrator Consultant to review falls with any injury to determine if they are reportable.	11/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245536		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/17/2025	
NAME OF PROVIDER OR SUPPLIER Green Lea Senior Living				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDALe, RR 2 BOX 49 , MABEL, Minnesota, 55954			
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F0609 SS = D	Continued from page 3 Based on interview and document review the facility failed to timely report to the State Agency (SA) a fall with serious injury for 1 of 1 resident (R1) who had multiple prior falls without fall assessments and implementation of appropriate fall interventions to prevent/mitigate risk of re-current falls. R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction (stroke). Review of R1's fall incidents identified R1 had falls on 9/26/25, 9/28/25, 9/30/25, and 10/1/25; no comprehensive analysis for causal factors were completed after each fall nor were appropriate interventions to prevent/mitigate the risk of falls and falls with major injury. R1's fall incident report dated 10/3/25 at 9:24 a.m., identified R1 was found on floor between door and bed. R1 had an injury above right eye that was swollen and bleeding, and two skin tears on right forearm. Predisposing factors of restless, gait imbalance, and weakness. R1 was sent to emergency department (ED) for evaluation. There was no indication a comprehensive fall investigation/analysis was completed. R1's progress note dated 10/3/25 at 9:38 p.m., identified R1 was sent out via ambulance earlier in the day due to a fall with head injury and at 2:57 p.m., the nurse called the hospital for an update and was informed that R1 was being kept for observation for a brain bleed. During an interview on 10/15/25 at 11:54 a.m., licensed practical nurse (LPN)-A stated on 10/3/25 she had called the hospital to check on R1 and was informed that R1 was being admitted to the hospital due to a brain bleed. LPN-A informed the assistant director of nursing (ADON) about R1's brain bleed. LPN-A assumed the ADON informed the administrator of R1's brain bleed following the fall; therefore, she did not report R1's injury to the administrator immediately. LPN-A explained she was under the impression that the incident needed to be reported to the administrator within two hours and was unaware of the reporting requirement to the SA. During an interview on 10/14/25 at 4:28 p.m., administrator stated R1's fall with serious injury had not been reported to the SA when the facility learned R1 sustained a brain bleed following a fall and should have been reported within two hours. Administrator was not aware the rationale the fall with serious injury was not reported to the SA in a timely manner or not at all. During an interview on 10/14/25 at 4:35 p.m., director of nursing (DON) stated when R1 had a fall on			F0609			

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F0609 SS = D	Continued from page 4 10/3/25 and sustained a brain bleed the ADON was in charge due to DON being on vacation, however, R1's fall with serious injury should have been reported within two hours of the facility's knowledge of the injury and that R1's fall was not reported to the SA. Review of the facility's Abuse Investigation and Reporting Policy dated 4/17/25, identified all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulation) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. - An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.	F0609		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F0641	F641 R1 5-day MDS assessment with an assessment reference date of 9/30/25 was modified on 11/7/25 to include residents' three falls since admission in section J1800. Resident Assessments Policy and Procedure was reviewed and updated on 11/6/2025. The facility has partnered with a third party MDS organization to ensure accuracy of the assessments that are completed. A review will be conducted of all residents' most recent MDS to ensure it was completed with accuracy. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) MDS Coordinator will be educated on the facility policy Resident Assessments by compliance date. Education included: ensuring MDS assessments include accurate data, with emphasis on fall-related items. MDS Coordinator was also educated on partnership with an outside MDS entity for ensuring assessment accuracy. Education on the policy was completed on 11/7/25. 2) The Director of Nursing will complete 3 MDS assessment audits per week for 3 months to ensure accurate coding on the MDS assessment. Audits will be	11/15/2025

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F0641 SS = D	Continued from page 5 resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 of 3 residents (R1) reviewed for residents who had falls. Findings include: R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction (stroke). R1's fall incident report dated 9/26/25 at 2:00 p.m., identified R1 had an unwitnessed fall from wheelchair in room. R1 stated she was trying to get to the bathroom. R1's progress note dated 9/28/25 at 7:17 p.m., indicated R1 fell from bed onto cushioned mat on the floor. R1's progress note dated 9/30/25 at 9:47 p.m., identified R1 had a fall at 8:50 p.m. R1 was found lying on the fall mat next to her bed. R1 had removed brief and only had on gripper sock on. R1's 5-day MDS assessment with an assessment reference date of 9/30/25, identified section J1800 was coded as R1 had not had any falls since admission/entry even though R1's records identified three falls since admission. During an interview on 10/17/25 at 1:04 p.m., Minimum Data Set Coordinator/registered nurse (MDS-RN) stated R1's MDS with an ARD date of 9/30 was not accurate. Section J1800 should have been marked that R1 had falls since admission, however, was marked that R1 did not have any falls since admission. MDS-RN stated that he referenced the Risk Management fall incident reports and reviews the progress notes during the ARD window, however, must have missed seeing R1's falls on 9/29/25, 9/28/25 and 9/30/25. Review of the facility's Resident Assessments Policy dated 10/2023, identified the following: A comprehensive assessment of each resident is completed at intervals designed by OBRA regulations and PPS requirements. Data from the MDS is submitted to the Internet Quality Improvement Evaluation System (IQEIS) as required. Policy	F0641	Continued from page 5 ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: November 15, 2025	

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F0641 SS = D	Continued from page 6 interpretation and implementation included the following: Information in the MDS assessments will consistently reflect information in the progress notes, plan of care, and resident observations/interviews.	F0641		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline	F0655	F655 R1 fall care plan was updated on 10/15/2025 to include current fall interventions and fall risk level. Baseline Care Plan Policy and Procedure was reviewed and updated on 11/6/2025. Admit checklist was revised to include adding the fall risk level and safety interventions to prevent/mitigate the risk of decline or injury from falls to the baseline care plan. Residents newly admitted within the last 20 days were also reviewed to ensure their baseline care plans addressed safety interventions to prevent/mitigate the risk of decline or injury from falls. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Licensed nurses who complete the admissions will be educated on Baseline Care Plan Policy and Procedure. Education will include ensuring the resident fall risk is identified on the baseline care plan, along with safety interventions to prevent/mitigate the risk of decline or injury from falls by compliance date. All licensed nurses will be educated on the facility policy Baseline Care Plans by compliance date. Education included: ensuring licensed nurses update the baseline care plan to include safety interventions to prevent/mitigate the risk of decline or injury from falls by the compliance date. Education on the policy was initiated on 11/7/25. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2) The Director of Nursing will complete audits on all new admissions weekly for 3 months to ensure their baseline care plan includes safety interventions to prevent/mitigate the risk of decline or injury from falls. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.	11/15/2025

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F0655 SS = D	Continued from page 7 care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to assure baseline line care plan addressed safety interventions to prevent/mitigate the risk of decline or injury from falls for 1 of 1 resident (R1) at risk for falls had a fall with major injury. Findings include: R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction (stroke). R1's Admission Nursing Assessment dated 9/25/25 (R1's admission date), identified R1 was alert and orientated to person, but not aware of time and place, used a wheelchair for mobility, had poor trunk control due to right sided deficit from stroke, and surface to surface transfer was not steady and needed staff assistance for transfers. R1's Morse Fall Scale (a tool used to assess a resident risk for falling) dated 9/25/25, identified R1 was moderate risk for falling. R1 had not have a history of falling, had impaired gait and overestimates or forgets limits. R1's fall risk identified R1 did not have more than one diagnosis, however, R1's diagnosis list did identify more than one diagnoses. R1's did not use ambulatory aide due to none/bedrest/wheelchair/nurse assist. R1's paper Temporary Care Plan dated 9/25/25, did not include a fall focus area nor fall prevention interventions even though the Morse Fall Scale identified R1 was at risk for falls. Although the care		F0655	Continued from page 7 Date of completion: November 15, 2025			

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F0655 SS = D	Continued from page 8 plan identified R1 was incontinent of bowel and bladder the temporary care plan did not identify a toileting program or schedule. The Temporary care plan identified R1 transferred with a full-body mechanical left with two staff. R1's therapy note impulsive (added see below-AO) R1's physical therapy (PT) treatment note dated 9/26/25, identified R1 was impulsive and had decreased alertness and judgement. R1's progress dated 9/28/25 and 9/30/25 included R1's bed was kept in low position and fall mat along bedside. R1's baseline care plan did not identify either of those interventions. R1's electronic health record (EHR) care plan dated 9/28/25, identified R1 was at high risk for falls related to confusion, incontinence, poor communication/comprehension, unaware of safety needs. Goal to not sustain serious injury. Intervention were as followed: anticipate and meet the resident needs, be sure call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt responded to all request for assistance, be sure the resident is wearing appropriate footwear socks and no-skid shoes and/or gripper socks, follow facility fall protocol, PT to evaluate and treat as ordered (was on PT caseload already). Intervention to care plan added on 10/9/25 were as followed: review information on past falls and attempt to determine root cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes; The resident needs activities that minimize the potential for falls while providing diversion and distraction. Resident needs to be in common area for supervision and enjoys 1:1 activities also has fidget items to utilize. R1's EHR care plan did not identify how R1 was to be transferred. R2's progress note dated 10/2/25, identified R1 was high fall risk and needed frequent checks. R1's care plan did not include frequent checks. R1's Physical Therapy Rehab Communication Form dated 10/3/25, identified R1 needed supervision when in wheelchair. R1 was a high fall risk and not to leave alone in room when in wheelchair. R1's baseline care plan did not indicate to not leave R1 alone in room when in wheelchair.			F0655			

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F0655 SS = D	Continued from page 9 R1's Physical Therapy Rehab Communication Form dated 10/8/25, identified R1 was to transfer with a sit to stand lift and must have two staff to assist and use gait belt. Staff to assist right hand up to bar and make sure right foot is in good position on foot plate. R1's baseline care plan did not indicate R1's transfers status had been changed from total mechanical lift to a sit to stand lift. During an interview on 10/10/25 at 11:30 a.m., nursing assistant (NA)-E stated staff will reference the care plan/Kardex located in the electronic health record (EHR) or look at the therapy recommendation paper. NA-E then logged on the EHR, however, was unable to locate R1's transfer status in her care plan/Kardex. nor locate the therapy recommendations for R1 on the therapy clipboard. During an interview and observation on 10/10/25 at 1:44 p.m., NA-G and NA-E entered R1's room to perform a transfer. NA-G brought in a full body mechanical lift, at which time NA-E informed NA-G that she did not think R1 was a full body mechanical lift, however, when she had checked R1's care plan/Kardex it did not identify how R1 was to be transferred. NA-G then left R1's room and stated she would go and check the care plan. NA-G then entered R1's room and provided the surveyor a piece of paper that had "therapy recommendation" on the top which was dated 10/8/25. The therapy recommendation stated R1 was to use a sit to stand lift for transfers with assist of two staff, assist right hand up to bar and make sure right foot in good position. NA-G stated she had to ask therapy to obtain this paper, because it was not on the therapy clipboard. NA-G stated last time she worked R1 was a full body mechanical lift and had not heard in report that her transfers status had changed. NA-G further stated R1's care plan had not been updated to reflect the change in transfer status. NA-G stated not having a resident's care plan updated timely could put the resident at risk for being transferred incorrectly and causing an injury. During an interview on 10/14/25 at 3:07 p.m., physical therapist (PT) stated recommendations for a resident the use a Rehab Communication Form and give four copies to the facility-one for director of nursing, one for the assistant director of nursing, one for nurses, one for nursing assistants. Therapy does have a licensed nurse sign for the communication form when it is dispersed to nursing. PT stated R1 was changed from a total mechanical lift on 10/8/25 when she returned from the hospital and would have expected R1's care plan to be updated as soon as the communication form was given to nursing.	F0655		

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F0655 SS = D	Continued from page 10 During an interview with Minimum Data Set Coordinator-RN (MDS-RN) stated baseline care plans should include a resident's fall risk and fall prevention interventions and should be updated as soon as possible to let staff know how to properly care for a resident. During an interview on 10/10/25 at 5:25 p.m., director of nursing (DON) stated R1's care plan had not updated to reflect the change in transfer status on 10/8/25, nor been updated to include fall risk, fall prevention interventions, low bed, fall mat. DON further stated, R1's care plan should have been updated as soon as possible, but "I just have not gotten to doing it yet." Review of the facility's Baseline Care Plan Policy undated, identified the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. Social services. vi. PASARR recommendation, if applicable. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable.		F0655				

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F0655 SS = D	Continued from page 11 a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented in the designated format. 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 4. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable. This will be provided by the MDS nurse/designee by the completion date of the comprehensive care plan.		F0655				
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review		F0689	F689 Policy and procedure, Falls and Fall Risk, Managing, Fall Risk Assessment, Assessing Falls and Their Causes, Falls-Clinical Protocol, Baseline Care Plan, and Comprehensive Care Plans Policy and Procedures reviewed and updated on 10/15/2025. Policy updated to include: nurse communication binder, licensed nurse at time of incident to update care plan and nursing assistant Kardex with new post fall intervention, RCA review and documentation and complete Morse Fall Assessment. R1 last fall was on 10/8/2025. R1 had a fall assessment completed on 10/15/2025 in addition to corresponding assessments that determine individualized interventions both immediate and long term. All of R1s falls since admission will have a RCA completed by the IDT by date of compliance and		11/15/2025	

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F0689 SS = SQC-J	Continued from page 12 the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of fall with major injury for 2 of 3 residents (R1, R4) who had falls. This resulted in an immediate jeopardy (IJ) for R1 who sustained a resulted in a subarachnoid hemorrhage (type of brain bleed) and was hospitalized. The IJ began on 9/30/25 after R1's third fall with no completion of a causal analysis or implementation of fall interventions which resulted in and/or could have mitigated the risk of R1's fall on 10/3/25 fall with major injury that required 5-day hospitalization and two subsequent falls on 10/8/25 upon readmission to the facility. The administrator and director of nursing (DON) were notified of the IJ on 10/14/25 at 5:31 p.m. The immediate jeopardy was removed on 10/17/25 at 2:50 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction (stroke). R1's hospital discharge summary dated 9/25/25, identified R1 was admitted to the hospital 9/6/25 and discharged to the facility on 9/25/25 with diagnoses that included cerebral vascular accident (CVA), diabetes, and bipolar disorder. The discharge summary indicated R1 required assist of two for activities of daily living and assist of two with total mechanical lift for transfers. R1's Admission Nursing Assessment dated 9/25/25, identified R1 was alert and orientated to person, but not aware of time and place, used a wheelchair for mobility, had poor trunk control due to right sided deficit from stroke, and surface to surface transfer was not steady and needed staff assistance for transfers. R1's Morse Fall Scale (a tool used to assess a resident risk for falling) dated 9/25/25, identified R1 was moderate risk for falling. R1 had impaired gait and overestimates or forgets limits. There was no further information included. R1's Temporary Care Plan dated 9/25/25, did not identify R1's level of risk for falling as identified in the Morse Fall Scale. R1's care plan identified R1 was assist of two with a full body mechanical lift, R1 was incontinent of bowel and bladder, but did not identify a toileting	F0689	Continued from page 12 documented in the clinical chart. R1s immediate interventions in place are the following: bed in lowest position, floor mat on floor when resident in bed, Right Upper Extremity lap tray when in wheelchair, and back contour cushion in place in wheelchair for positioning. R1 has also moved to a room closer to the nurse's station. IDT meet on 10/15/2025 to review R1's falls and RCA and ensure appropriate fall interventions are in place based on resident's current needs and resident's status based on the individual falls and the RCA. R1 falls on 9/28/25 at 7:17pm, 9/30/25 at 8:50pm, and 10/8/25 at 4:10pm were added to risk management, RCA completed, and care plan updated based on the individual falls and the RCA. R1's fall care plan was updated on 10/15/2025 to include current fall interventions and fall risk level. R4's falls in the past 30 days will be reviewed by the IDT to ensure a RCA is completed and ensure appropriate fall interventions are in place based on resident's current needs and resident's status based on the individual falls and the RCA. R4 fall risk care plan will be updated based on RCA completed. R4 Morse Fall Assessment was completed on 10/30/2025. All high risk fall residents (based on Morse Fall Assessment) who had a fall in the past 30 days will have a RCA completed based on the fall and reviewed by the IDT on 10/16/2025 to ensure the high risk resident's care plan/Kardex interventions are individualized to remove/negate the risk of falls based on potential risks of falls and staff will be educated via nursing communication binder on their individual fall interventions. All residents greater than 30 days was reviewed to ensure care plan fall interventions are current. All current resident in the facility had their most recent fall risk assessment review to verify accuracy and redone if not current. All current residents in the facility will have their care plan updated to include their fall risk level. The facility identified 26 residents at high risk for falls. The facility identified 8 of those 26 residents had falls in the past 30 days as of 10/16/2025.	

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F0689 SS = SQC-J	Continued from page 13 routine/schedule. Further the care plan did not include any interventions to prevent/reduce falls including applicable interventions associated with R1's fall risk factors identified on the Morse Fall Scale (impaired gait and overestimates or forgets limits). R1's fall incident report dated 9/26/25 at 2:00 p.m., identified R1 had an unwitnessed fall from wheelchair in room. R1 stated she was trying to get to the bathroom. R1 was incontinent of urine, and the floor was wet. Review of facility incident reports and R1's record did not include a comprehensive fall investigation and analysis to determine all potential risk factors for which appropriate interventions would be implemented to prevent/mitigate the risk for falls. Although the progress note indicated one potential causal factor of R1's fall was attempting to use the bathroom, there was no indication R1's care plan was revised to include associated interventions. R1's physical therapy (PT) treatment note dated 9/26/25, identified R1 was impulsive and had decreased alertness and judgement. R1's care plan did not identify R1 was impulsive nor include interventions to decrease the risk of falls related to R1's impulsivity. R1's progress dated 9/28/25 at 2:19 a.m., included R1's bed was kept in low position and fall mat along bedside. R1 was found in bed making squirming movements from her bed to the mat, incontinent of urine, and did not use the call light. Subsequent progress note at 4:26 a.m., identified R1 was found scooting herself from the bed to the floor mat. R1 fall focus care plan initiated on 9/28/25, identified R1 was high risk for falls related to confusion, incontinence, poor communication/comprehension, and unaware of safety needs. R1's "impulsivity" that was documented by PT on 9/26/25 was not included in the listing of risk factors. Interventions included: anticipate and meet the needs of the resident, be sure call light is within reach and encourage the resident to use it for assistance, the resident needs prompt response to all requests for assistance, ensure the resident is wearing appropriate footwear and no-skid gripper shoes and/or gripper socks. R1's care plan did not include the interventions of low bed nor the fall mat which were identified in the 9/28/25 at 2:19 a.m. progress note. R1's progress note dated 9/28/25 at 7:17 p.m., indicated R1 fell from bed onto cushioned mat on the floor. Subsequent note at 7:19 p.m. included R1 forgets her physical limitations and attempts to move or stand and cannot support self. No further information was documented. There was no corresponding incident report, no indication of a comprehensive analysis to identify causal factors, and no indication R1's care plan was revised.	F0689	Continued from page 13 Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All clinical staff (RN's, LPN's, TMA's, and CNA's) will be re-educated on the facility policies, Falls and Fall Risk, Managing, Fall Risk Assessment, Assessing Falls and Their Causes, Falls-Clinical Protocol, Baseline Care Plan, and Comprehensive Care Plans Policy and Procedures in person 1:1 education and a competency will be completed and signed by the employee. The education includes review of policy and procedure including ensuring licensed staff are aware of adding an immediate intervention post fall that negates the risk of recurrent falls with any resident that falls, and this intervention will be listed on the risk management report that is completed with each incident. Licensed staff have also been educated to update the care plan and nursing assistant Kardex and document fall intervention in the resident's chart along with nursing communication binder. Licensed Nurse have also been educated on RCA and required documentation in the resident chart. TMAs and CNA's were educated on care plans and how to access resident fall interventions on the Kardex and the nursing communication binder to ensure they are aware of where to located individual fall interventions. The education on this policy will be initiated beginning on 10/15/2025 and will be completed by date of compliance. Staff that have not yet been scheduled to work prior to compliance date will complete education prior to their next scheduled shift. 2) Agency nursing staff orientation checklist will be updated to include education on the above policies and procedures and fall requirements. 3) The Director of Nursing will complete audits on 5 random clinical staff weekly for 3 months to ensure clinical staff are aware of resident fall interventions and how to locate them. The Director of Nursing will audit every fall incident report to ensure an immediate intervention has been implemented per policy, RCA completed, care plan updated, and intervention communicated in the nursing communication binder. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 4) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.	

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F0689 SS = SQC-J	Continued from page 14 R1's progress note dated 9/30/25 at 9:47 p.m., identified R1 had a fall at 8:50 p.m. R1 was found lying on the fall mat next to her bed. R1 had removed brief and only had on gripper sock on. R1 was very fidgety and unable to remain still. There was no corresponding incident report, no indication of a comprehensive analysis to identify causal factors, and no indication R1's care plan was revisedR1's minimum data set (MDS) dated 9/30/25 (assessment reference date), identified R1 was cognitively intact, had other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self) that occurred 1 to 3 days, had impairment on one side for upper and lower extremities, was frequently incontinent of bowel and bladder, used a wheelchair, and was dependent for all transfers/toileting. The MDS identified R1 did not have any falls since admission even though R1's record had documented falls on 9/26/25, 9/28/25, and 9/30/25. R1's fall incident report dated 10/1/25 at 8:50 a.m., identified R1 was sitting in the lobby when she leaned too far forward and fell out of her wheelchair. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication R1's care plan was revised. R1's PT treatment note dated 10/1/25 (no time stamp), identified R1 had a fall in the lobby prior to "be treated". PT educated staff on therapy ball R1 used for left upper extremity and added pillow behind back to increase comfort and decrease need to be repositioned. There was no indication R1's care plan was revised to include these recommendations. R1's fall incident report dated 10/3/25 at 9:24 a.m., identified R1 was found on floor between door and bed. R1 had an injury above right eye that was swollen and bleeding, and two skin tears on right forearm. Predisposing factors of restless, gait imbalance, and weakness. R1 was sent to emergency department (ED) for evaluation. Report indicated R1 had self-propelled to an area where R1 was not observed by staff. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R1's hospital emergency department (ED) note dated 10/3/25, identified R1 was seen in the ED following an unwitnessed fall in the skilled nursing facility after trying to get out of bed. R1 had a hematoma (a localized collection of blood outside the blood vessels) and a small laceration on the right lateral (side) eyebrow and a skin tear on right forearm and computed topography (CT) of the head showed findings concerning for traumatic subarachnoid hemorrhage and was admitted for observation. R1's therapy recommendation dated 10/3/25 (no time stamp), identified R1 was to have supervision when in wheelchair due to R1 was high fall risk and do not			F0689	Continued from page 14 Date of completion: November 15, 2025		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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F0689 SS = SQC-J	Continued from page 15 leave in room alone when in wheelchair. There was no indication R1's care plan was revised to include these interventions. During an interview on 10/10/25 at 5:55 p.m., therapy director (TD) stated R1 had been impulsive and had poor safety awareness since admission. TD had communicated this to the nursing staff since admission and placed a sign in R1's room after her fall on 10/3/25 to ensure staff did not leave her alone in her room when she returned from the hospital. R1's hospital discharge summary dated 10/8/25, identified R1 was hospitalized 10/3/25 through 10/8/25 following a fall. R1 was kept for observation and was discharged back to the nursing facility on 10/8/25 at 9:30 a.m. In review of R1's record there was no documentation of what time R1 returned to the facility. There was no indication of revisions to R1's care plan for falls upon re-admission. R1's progress note dated 10/8/25 at 12:03 p.m., identified R1 stays in lobby for staff to keep an eye on her while awake. R1's fall incident report dated 10/8/25 at 1:10 p.m., identified R1 was found lying on the floor in her room off the fall mat. R1 stated she rolled out of bed and just kept rolling and rolling. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication R1's care plan was revised. R1's progress note dated 10/8/25 documented at 9:46 p.m., identified at 4:10 p.m., R1 was observed attempting to stand up from wheelchair in main living area. R1 fell to one knee and staff quickly assisted R1 by lifting her back into her wheelchair. No injury. There was no indication an incident report was completed, no comprehensive analysis, and no indication R1's care plan was revised. R1's fall incident report dated 10/8/25 at 7:15 p.m., identified R1 was found on the floor in the main living area. Staff reported hearing R1's head hit the floor. R1 sustained a large skin tear on tip of right forearm. Ambulance called and R1 was transported to ED at 7:50 p.m. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R1's progress note dated 10/8/25 at 11:36 p.m., identified that facility received a call from hospital ED and that R1's "test came back negative" and R1 will be sent back to facility. R1's bed was placed near the nursing station and will plan to always keep R1 in view. R1's MDS dated 9/30/25 triggered the fall Care Area Assessment (CAA) which was signed as completed on 10/8/25, identified R1 had a "potential" (versus actual) problem for falls due to taking high risk drugs (antidepressant). The CAA did not include all of R1's risk factors identified in R1's record nor her seven falls, one which resulted in major injury. R1's progress note dated 10/9/25 at 2:56 a.m., identified R1 arrived back to the facility at 1:50 a.m.	F0689		

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F0689 SS = SQC-J	Continued from page 16 Providing 1:1 as able and bed in low position and fall mat. R1's fall focus care plan had been updated on 10/9/25 to the following intervention: R1 needs activities to minimize the potential for fall while providing diversion and distraction. R1 needs to be in common area for supervision and enjoys 1:1 activity and had fidget items to utilize. R1's records were reviewed between 10/9/25 to 10/13/25, it was not evident the 1:1 supervision was implemented with the exception of the mentions in progress note dated 10/9/25 and 10/11/25. The duration of the 1:1's on 10/9/25 and 10/11/25 was not identified. During an observation and interview on 10/10/25 at 10:54 a.m., R1 had a sutured laceration above her right eye and yellowish/green bruise below the eye. Nursing assistant (NA)-E and NA-K were assisting R1 onto a commode. Two signs were placed on the wall near R1's bed that directed "Press the red button if you need help or need to get up." R1 stated the sign meant to remind her to use the call light or to just get up if she needed something." NA-E stated she had heard R1 had fallen a while ago that resulted in her right eye with bruises. NA-E stated she was unaware of what the fall prevention interventions were for R1 because she was in training and had not been shown how to look up the interventions. During an interview on 10/10/25 at 12:03 p.m., registered nurse (RN)-B stated when a resident falls, she would perform range of motion, vitals, and enter the information in the Risk Management tab in the electronic health record (EHR). RN-B was unaware of how to complete a fall causal analysis, nor did she know how to add/update a resident's care plan. RN-B explained floor nurses did not complete causal analysis nor update the care plans, management would perform those tasks. During an interview on 10/10/25 at 4:20 p.m., NA-G stated R1 would self-transfer since admission. R1's fall prevention interventions were a low bed with a fall mat on the floor. NA-G was not sure how other staff would know R1 needed those. NA-G stated R1 had been on 1:1 supervision for a short time but was not sure if they had stopped or if that was ongoing. Staff try and 'keep eyes' on R1 when she is in her wheelchair, but "sometimes we get busy and may not watch her as close as we should." NA-G could not articulate any additional fall prevention interventions for R1 and stated she would have to reference a nursing assistant communication book that had each resident's care plan in it, however, was not able to find a care plan for R1 in the book. During an interview on 10/10/25 at 5:25 p.m., director of nursing (DON) stated R1 was a high fall risk upon admission due to not being aware of her own limitations. DON reviewed R1's fall documentation since admission. DON stated none of R1's falls included a comprehensive investigation and causal analysis. R1's			F0689			

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F0689 SS = SQC-J	Continued from page 17 care plan had not been revised after each fall and not all interventions documented in the record were represented on the care plan. During an interview on 10/14/25 at 2:53 p.m., trained medication aide (TMA)-C stated he was unaware of all the fall prevention interventions the facility was doing for R1. He was not able to locate the Kardex in R1's electronic health record and stated the only fall intervention he was aware of was to keep R1 in eyesight when she is up in her chair. TMA-C stated they try to do this as "best they can." During an interview on 10/14/25 at 3:01 p.m., nursing assistant (NA)-J could not articulate what the fall prevention interventions were for R1. NA-J stated normally there was a book with the Kardex in it and this would tell staff what the fall interventions would be, however, NA-J could not find R1 in the book. NA-J stated she would then go to the kardex/care plan in the EHR (electronic health record) to determine fall prevention interventions, however, upon looking at R1's kardex/care plan she only identified that R1's call light should be within reach. The immediate jeopardy that began on 9/26/25, was removed on 10/17/25 at 2:50 p.m., when it was verified, the facility implemented the following: -R1 had an updated fall risk assessment completed. -R1's falls since admission had a root cause analysis and appropriate fall prevention interventions added to the clinical chart. - Interdisciplinary team met and reviewed R1's falls and root cause analysis to ensure appropriate fall interventions in place based on resident needs and resident's status based on the individual falls and root cause analysis. -R1's care plan updated to include current fall interventions and fall risk level. -All high risk fall residents who had a fall in the past 30 days had a root cause analysis completed and care plans were updated to remove/negate the risk of falls based on potential risks of falls. -Staff were re-educated on the facility's falls and fall risk, managing, fall risk assessment, assessing falls and their causes, falls-clinical protocol, baseline care plan, and comprehensive care plan policies. -All clinician staff was re-educated on the facility policies, ensuring licensed staff adding immediate intervention post fall, updating care plan, -Agency nursing staff orientation checklist update to include education on fall prevention policies and procedures. R4 R4's face sheet dated 10/16/25, identified diagnoses of Huntington's disease (a rare neurodegenerative disorder that causes progressive physical, cognitive, and psychiatric symptoms), muscle weakness, and history of falling. R4's Admission Minimum Data Set (MDS) dated 8/27/25, identified R4 was cognitively intact,	F0689		

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F0689 SS = SQC-J	Continued from page 18 continent of bowel and bladder, needed moderate assistance for transfers, and had a fall in the last month prior to admission. R4's Morse Fall Scale dated 8/26/25, identified R4 was high risk for falling due to weak gait; overestimates or forgets limits. R1's Morse Fall Scale did not identify any further information. R4's fall focus care plan dated 9/5/25, identified R4 was high risk for falls. Goal was that R4 would not sustain serious injury. Interventions included: anticipate needs; be sure call light is within reach; ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R4's fall incident report dated 9/4/25 at 8:36 p.m., identified R4 had an unwitnessed fall and was found on knees with them under the bed holding onto the railing. R4 stated she pushed herself back to her room after the tractor pull and just wanted to go to bed but could not reach the call light. R4 was incontinent of urine at the time of the fall. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R4's fall incident report dated 10/2/25 at 6:40 p.m., identified R4 was self-transferring from wheelchair to the bathroom with walker and slipped out of wheelchair. Vital signs taken and assisted from ground. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R4's fall incident report dated 10/14/25 at 7:15 p.m., identified R4 was found in room with bottom on the floor, back to bed, and legs straight out towards door. R4 stated she was going to the bathroom. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R4's fall focus care plan was updated on 10/15/25 to include fall prevention intervention to toilet every two hours while awake and after all meals. However, R4's Treatment Administration Record (TAR) identified R4 was to be checked on every hour beginning on 10/15/25 at 1:00 p.m., due to R1 having recent falls. R4's fall incident report dated 10/15/25 at 8:05 p.m., identified R4 was found on her bottom scooting to the toilet. R4 was using hands on the ground to propel herself, knees bent with feet on the floor, and bottom on the ground. R4 stated, "I was crawling to the bathroom and did not want to pee the bed." R4's incident report did not specify when R4 was toileted last. There was no immediate intervention identified and no indication of a comprehensive analysis to identify causal factors until 10/16/25 at 10:51a.m. During an interview on 10/17/25 at 3:05 p.m., DON stated R4's falls had not been comprehensively assessed or had any causal analysis completed for the falls prior to 10/15/25 to		F0689				

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F0689 SS = SQC-J	Continued from page 19 ensure the appropriate fall prevention interventions were in place. Review of the facility's Fall and Fall Risk, Managing Policy dated 10/15/25, identified the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk: The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period, as needed. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. Staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling, as appropriate. Position-change alarms may be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Fall Risk: If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls, as needed. Documentation: - The licensed nurse shall promptly initiate and document the accident or incident.	F0689			

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F0689 SS = SQC-J	Continued from page 20 - Licensed nurses will update the care plan with the new fall intervention post fall. - Licensed nurse will update the resident's Kardex with fall intervention. - Licensed nurse will document the new fall intervention in the nursing communication binder for clinical staff to review. - Licensed nurse will complete a Morse Fall Scale with each new fall. -IDT will meet on every business day to review resident falls and interventions. Progress note will be made in the residents' record of this review.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the	F0690	F690 R4 will have a new continence assessment completed. Based on the assessment, R4 will be reviewed to assess current continence status and contributing factors. A personalized continence care plan will be developed for R4, including a scheduled toileting program based on R4's needs and preferences. DON consulted with R4 provider on 11/3/25 regarding urinary frequency. UA was obtained on 11/3/25, which was negative. R4's provider wrote a new order on 11/4/25 for a medication for overactive bladder. Incontinence Policy and Procedure was reviewed and updated on 11/6/2025. All current residents with bladder incontinence will be audited to ensure they have completed comprehensive assessment and if applicable, toileting schedule to ensure their continence needs are met. Care plans will be updated to reflect the toileting needs. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All nursing staff (licensed nurses, TMAs, nursing assistants) will be educated on the facility policy Incontinence by compliance date. Education included: ensuring staff are aware of resident toileting needs, and will be reflexed on the care plan/Kardex. Education on the policy was initiated on 11/7/25. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift.	11/15/2025

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F0690 SS = D	Continued from page 21 facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure received appropriate treatment and services to prevent decline in incontinence and urinary symptoms and further failed to develop and implement an individualized toileting program for 1 of 1 resident (R4) who had a diagnoses of Huntington's disease, was continent upon admission, but had fluctuating symptoms of incontinence, urgency, and frequency. Findings include: Urge Incontinence is associated with detrusor muscle over activity resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full). It is characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). The resident can feel the need to void but is unable to inhibit voiding long enough to reach and sit on the commode. It is the most common cause of urinary incontinence in elderly persons. " Stress Incontinence is associated with impaired urethral closure which allows small amounts of urine leakage when intra-abdominal pressure on the bladder is increased by sneezing, coughing, laughing, lifting, standing from a sitting position, climbing stairs, etc. Mixed Incontinence is the combination of urge incontinence and stress incontinence. Many elderly persons (especially women) will experience symptoms of both urge and stress. " Overflow Incontinence is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended from urine retention. Symptoms of overflow incontinence may include: weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. Functional Incontinence refers to loss of urine that occurs in a resident whose urinary tract function is sufficiently intact that he/she should be able to maintain continence, but who cannot remain continent because of external factors other than inherently abnormal urinary tract function. Examples may include		F0690	Continued from page 21 2) The Director of Nursing will complete audits on 3 random residents weekly for 3 months to ensure assessments, care plan, and toileting schedule are followed to ensure appropriate care and services are implemented. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: November 15, 2025			

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F0690 SS = D	Continued from page 22 inability to get to the bathroom on time, Physical weakness or poor mobility/, Environmental impediments including excessive distance from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access. R4's face sheet dated 10/16/25, identified diagnoses of Huntington's disease (a rare neurodegenerative disorder that causes progressive physical, cognitive, and psychiatric symptoms), muscle weakness, and history of falling. R4's continence evaluation assessment dated 8/27/25, identified R4 had history of incontinence of bladder which was a gradual onset. Symptoms over past 6 months were improving where R4 had one accident per week. The assessment did not identify or include additional information pertaining when and under what if any circumstances led to the incontinence, does not identify the type of incontinence, and does indicate interventions and/or treatments that had improved the incontinence. The assessment also included R4 had some leakage coded as "soil/wet underwear only". R4 did not symptoms of urge incontinence and did not have symptoms of stress incontinence. R4 was aware of the urge to void and on average she was able to hold on after feeling the urge to void for more than 5 minutes. In the section Overflow Incontinence, the coded answers identified R4 felt her bladder was emptying completely, she was aware when urine was being passed, no issues with starting or passing urine, and no dribbling after passing urine. R4 was "occasionally aware she was wet" which was not further assessed to determine the type of incontinence that would contribute to wetness without R4's awareness. The assessment also identified R4 had mixed incontinence even though the assessment identified she did not have symptoms of stress and urge incontinence. R4's risk factors for bladder incontinence included diagnosis of cognitive impairment (not listed on diagnosis list), Huntington's disease, prescribed antipsychotic, and required one staff assistance with walker. Not applicable was marked for "voiding record initiated" however did not identify what R4's routine voiding patterns were. The summary section was blank. R4's Admission Minimum Data Set (MDS) dated 8/27/25, indicated R4 did not have cognitive impairment. R4 required moderate assistance for toilet transfers, continent of bowel and bladder, and had intact cognition. Review of R4's Point of Care (POC) task documentation		F0690				

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F0690 SS = D	Continued from page 23 of bladder continence from dates 8/26/25 through 9/3/25- identified R4 was continent of bladder. R4's progress notes reviewed from between 8/26/25 through 9/4/25 identified R4 was continent of bowel and bladder; progress notes did not indicate any concerns or changes in voiding patterns or urinary function. R4's physician visit dated 9/4/25 identified reason for visit was new admission. R4 was admitted to the facility after a fall at home and required hospitalization where she was found to have cystitis (urinary tract infection-UTI).and was treated with antibiotics. The visit did not address and/or mention status of incontinence. R4's progress note dated 9/6/25 at 5:20 a.m. included R4 is having an increase in urinary urgency, she was unable to void but reports the urge to. Denies dysuria. No back or flank pain. Urine is normal and without any concerns. Nursing staff report new onset urinary incontinence within the last day for unknown reason. Continent tonight. Progress note at 1:13 p.m. indicated R1 requested toileting often not always able to void and was occasionally incontinent of urine. R4's progress note dated 9/7/25 indicated R4 was occasionally incontinent of urine but verbalizes toileting needs. R4's progress note dated 9/8/25 indicated R4 used the call light 5 times to request toileting assistance. Continues to have urinary urgency. Voiding amount minimal each time. Urine appearance is normal. R4's Care Area Assessment (CAA) signed 9/8/25, identified a potential problem triggered for urinary incontinence. Modifiable risk factors included pain, urinary tract infection, and restricted mobility. Medications included anticholinergics and antipsychotics. The objective for care planning was to minimize risk of incontinence. due to needing assistance with toilet use and/or perineal cares during the assessment period. No other information was included. R4's POC documentation indicated R4 had a change in continence on 9/4/25. Documentation identified incontinent episodes on 9/4/25, 9/5/25, 9/6/25, 9/8/25, 9/10/25, 9/12/25, 9/13/25, and 9/14/25. R4's POC documentation between 9/15/25 through 9/22/25, identified R4 did not have incontinence. R4's progress notes reviewed 9/9/25 between 9/22/25,		F0690				

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F0690 SS = D	Continued from page 24 identified R4 was continent of bladder ten days (9/9/25, 9/10/25, 9/11/25, 9/13/25, 9/14/25, 9/15/25, 9/16/25, 9/17/25, 9/18/259/19/25, and 9/22/25) and had frequency on 9/12/25, 9/14/25 and 9/18/25 (frequency and burning with urination). R4's physician visit dated 9/22/25 indicated R4 was seen for urinary frequency and some episodes of urinary incontinence, treated for a UTI when she was hospitalized and has urinary frequency here. Staff feel like the frequency is getting worse. R4 denies any burning or pain. She is not sure if she has really noticed the urinary frequency and there is "nothing wrong". The physician ordered a urine analysis. R4's progress note dated 9/24/25 included did not show infection. R4's POC documentation between 9/23/25 through 10/4/25 R4 did not have any incontinent episodes except on 9/24/25, 9/29/25, 10/1/25, 10/2/25, and 10/4/25 with other days between R1 was continent of urine. R4's POC documentation between 10/5/25 through 10/11/25, identified R4 did not have any incontinent episodes. Between 10/12/25 through 10/17/25, identified R4 had episodes of incontinence on 10/12/25, 10/13/25, 10/14/25 and 10/15/25. R4's progress notes 9/23/25 through 10/17/25, identified R4 was continent of urine on 9/25/25, 9/26/25, 9/27/25, 9/28/25, 9/29/25, and 9/30/25. R4 had episodes of needed to urinate frequently (every 30 minutes to 1 hour) on 9/24/25 and 10/15/25. Review of R1's care plan indicated it was not initiated until 10/1/25 even though the CAA's were signed on 9/8/25. Further the care plan did not include a focus area that addressed R1's urinary continence that included goals and interventions that would prevent decline in bladder incontinence and/or maintain in addition to manage R4's urinary symptoms. R4's activities of daily living (ADL) focus care plan, initiated on 10/1/25, identified R4 had a self-performance deficit related to confusion, impaired balance, and Huntington's Disease. Corresponding interventions included: dependent on staff for transferring with gait belt and walker, transfer to toilet with assist of one and able to wipe herself after she is done. R4's care plan did not identify an individualized toileting plan. R4's fall focus care plan identified a new intervention on 10/15/25 to toilet every two hours while awake and after each meal however R4's record did not include a corresponding comprehensive bladder assessment and/or voiding diary		F0690				

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F0690 SS = D	Continued from page 25 that identified how that toileting schedule was determined. In review of R4's revealed although incident reports identified R4 had four falls (9/4/25, 10/2/25, 10/14/25, and 10/15/25) in which documentation indicated toileting as a causal factor there was no indication of a comprehensive bladder assessment was completed to determine type and/or possible changes in bladder function. Additionally, there was no indication of assessment to determine an appropriate toileting program/schedule. During an observation and interview on 10/17/25 at 8:30 a.m., R4 stated staff did not offer to take her to the bathroom regularly and further stated "they think I only need to go once per day, but I need to go more than that. Sometimes I pee the chair, recliner, and bed. This makes me feel terrible and like a baby." R4 then began to cry and stated, "Sometimes I cannot find the call light and just have to try and take myself to the bathroom, but I fall when I try and I just want to be able to able to keep my bladder control like I did when I first came." During an interview on 10/16/15 at 9:22 a.m., licensed practical nurse (LPN)-A stated that the standard for toileting people is that all residents are toileted every two hours. LPN-A was unsure how staff were keeping track of how often residents were toileted. R4 did not have a toileting plan in place prior to 10/15/25. During an interview on 10/10/25 at 4:20 p.m., nursing assistant (NA)-G stated staff tried to toilet every resident every two hours. NA-G was not aware if R4 had a different toileting schedule. NA-G stated R4 had been having more incontinent episodes lately. R4 would normally ask for assistance to use the bathroom however would attempt to take herself at times. During an interview on 10/17/25 at 3:35 p.m., director of nursing (DON) stated R4 was continent on admission and did have a toileting schedule added to her care plan on admission. DON reviewed R4's record, she explained the documentation identified R4's incontinence had worsened to frequently incontinent of urine. DON thought the increase in incontinence was because staff were not aware of how often R4 should be toileted. Review of the facility's Incontinence Policy undated, identified the facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical			F0690			

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F0690 SS = D	Continued from page 26 condition is or becomes such that continence is not possible to maintain.	F0690		
F0839 SS = F	Staff Qualifications CFR(s): 483.70(e)(1)(2) §483.70(e) Staff qualifications. §483.70(e)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(e)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 4 of 7 facility employed nursing assistants' (nursing assistant (NA)-B, NA-H, NA-I, and NA-L) certificates were current with the states nursing assistant registry. This had the potential to affect all thirty-two residents that resided in the facility. Findings include: Review of the State of Minnesota Nursing assistant registry on 10/16/25 identified the following: -NA-B's nurse aide certificate expired on 7/24/25. -NA-H's nurse aide certificate expired on 7/24/25. -NA-I's nurse aide certificate expired on 7/24/25. -NA-L's nurse aide certificate expired on 7/24/25. The facility's employee records were reviewed on 10/16/25 and identified NA-B, NA-H, NA-I, and NA-L were scheduled and completed shifts from 7/25/26 thought 10/16/25 with an expired nurse aide certificate. During an interview on 10/16/25 at 12:25 p.m., director of nursing (DON) stated she was not aware that NA-B, NA-H, NA-I, and NA-L had been working without a current nursing assistant certificate since 7/25/25. DON further stated she was not responsible for ensuring that staff had a current license/certificate and was unsure who was responsible for ensuring staff maintained their certification and/or professional	F0839	F 839 Staff Qualifications Human Resources Director, or designee, is responsible for maintaining and ensuring the validity and current status of individual certification/license. An individual will not be employed and/or will be terminated from employment (whichever case may apply) if: a. The individual has lost licensure/certification for any reason, or b. The individual has disciplinary action in effect against his or her professional license by a state licensure body as a result of finding abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. Any licensed/certified employee is responsible for maintaining continuing education hours as required for current licensure/certification status. Any licensed/certified employee is responsible for submitting verification for licensure/certification renewal to Human Resources prior to expiration. An audit of all staff license and certification was completed 11/5/2025 and will be completed every six months moving forward by Human Resources or designee. If a license or certification is found to be missing the staff member will be immediately removed from the floor and removed from the schedule until their license or certification is reinstated. Human Resources or designee will ensure that all licensure or certification is current at time of hire and enter the information into the facility's employee software system and update the information as needed. Human resources or designee will also maintain the NAR.	11/15/2025

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F0839 SS = F	Continued from page 27 licenses. During an interview on 10/16/25 at 12:05 p.m., administrator stated she had not been aware that NA-B, NA-H, NA-I and NA-L nursing assistant certificates expired and that the facility did not have process in place to ensure verification of licensed/certified staff's credentials are verified that they are current. Administrator further stated the responsibility to ensure the licenses/certificates are currently would be "ultimately" her responsibility and it was not completed. Review of the facility's License Verification Policy undated, identified all personnel that require a license, or certification shall be verified through the appropriate issuing agency. Policy Explanation and Compliance Guidelines included the following: 1. The Human Resources Director, or designee, is responsible for maintaining and ensuring the validity and current status of individual certification/licensure. 2. An individual will not be employed and or/will be terminated from employment (whichever case may apply) if: a. The individual has lost licensure/certification for any reason, or b. The individual has a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. 3. Any licensed/certified employee is responsible for maintaining continuing education hours as required for current licensure/certification status. 4. Any licensed/certified employee is responsible for submitting verification of licensure/certification renewal to Human Resources prior to expiration.	F0839		
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F0867	F0867 – QAPI/QAA Improvement Activities Deficiency Summary: The facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee effectively identified, analyzed, and responded to resident care issues, including developing and implementing performance improvement action plans for identified areas of concern. Specifically, the facility did not analyze or develop a corrective action	11/15/2025

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F0867 SS = F	Continued from page 28 policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;	F0867	Continued from page 28 plan in response to a significant increase in resident falls during September 2025, resulting in a missed opportunity to prevent serious injury. --- PLAN OF CORRECTION 1. Corrective Action Taken for the Residents Affected: The facility immediately conducted a comprehensive analysis of all resident falls occurring between August and October 2025, including root cause analysis for each event. Interventions were updated and individualized in each resident's care plan. ---2. Corrective Action to Identify Other Residents Who Could Be Affected: A 3-month review of all clinical quality indicators (including falls, pressure injuries, weight loss, infections, and medication errors) was completed to ensure other high-risk, high-volume, or problem-prone areas were being properly monitored through the QAPI process. No additional gaps were found where trends or concerns were not addressed by the committee.--- 3. Systemic Changes to Ensure the Deficient Practice Will Not Recur: a. QAPI Structure and Function · The QAPI Committee was restructured to include: Administrator, Director of Nursing (Chair), Medical Director, Infection Preventionist, Rehab Director, Dietary Manager, MDS Coordinator, and Social Services. · Committee will meet monthly (minimum) and as needed for emergent issues. · A QAPI meeting template was created to ensure consistent documentation of data trends, analysis, and corrective actions. b. Data Collection & Analysis · The DON or designee will ensure that data is analyzed for trends, with root cause analysis completed for any increase or pattern identified. c. Falls Performance Improvement Project (PIP) · A Falls PIP was initiated on October 28, 2025, to address the rise in fall frequency.	

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F0867 SS = F	Continued from page 29 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:		F0867	Continued from page 29 · The PIP includes: o Interdisciplinary team review of each fall within 24 hours. o Root cause identification (e.g., toileting needs, environment, medication, time of day). o Implementation and follow-up of corrective actions. o Monthly summary of outcomes shared in QAPI. o PDSA (Plan-Do-Study-Act) cycle used to measure effectiveness. d. Staff Education · All QAPI Committee members were re-educated on: o CMS QAPI regulations (§483.75). o Systematic root cause analysis. o PDSA cycle use for improvement tracking. o Requirements to identify and address all high-risk, high-volume, and problem-prone areas. · All department heads were educated on timely reporting of data trends and adverse events to the QAPI Committee. e. Policy & Procedure Update · The QAPI Change Process Policy was reviewed and revised on October 25, 2025, to include: o Defined data sources and responsibility for data submission. o Monthly review and analysis expectations. o Required written action plan when trends are identified. o Tracking and evaluation of improvement outcomes to ensure sustained progress. --- 4. Monitoring to Ensure Ongoing Compliance: · The Administrator or designee will review QAPI minutes monthly to verify that all areas of high-risk,			

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F0867 SS = F	Continued from page 30 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded to identified resident care issues by developing and implementing action plans for process improvement identified resident care issues related to high number of falls. This had the potential to affect all 32 residents residing in the facility. Findings include: SEE F689: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of fall with major injury for 2 of 3 residents (R1, R4) who had falls. This resulted in an immediate jeopardy (IJ) for R1 who sustained a resulted in a subarachnoid hemorrhage (type of brain bleed) and was hospitalized. Review of the QAPI facility minutes for past 6 months identified the following: -5/8/25 QAPI meeting minutes identified two falls for month of April and falls isolated (one with no injury and 1 with minor injury). No trends identified. -6/12/25 QAPI meeting minutes identified one fall for the month of May and fall was isolated and no injury. No trends identified. -7/10/25 QAPI meeting minutes identified two falls for the month of June falls were isolated and one with no injury and one with minor injury. No trends identified. -8/14/25 QAPI meeting minutes identified one fall for the month of July-isolated fall with no injury. No trends identified. -9/11/25 QAPI meeting minutes identified the facility had no falls for the month of August.	F0867	Continued from page 30 high-volume, or problem-prone care are analyzed with action plans as needed. · The QA/PI Committee will audit all falls, adverse events, and related PIPs monthly for six months to ensure root cause analyses and follow-up actions are documented. · The results of all QAPI monitoring will be reported to the RN consultant quarterly for review and oversight. · The QA/PI Committee will continue to evaluate the effectiveness of implemented corrective actions to ensure improvements are sustained. --- 5. Completion Date: November 30, 2025	

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F0867 SS = F	Continued from page 31 Review of the facility fall incident reports between 9/9/25 through 9/30/25 identified there were a total 9 falls. -10/9/25 QAPI meeting minutes identified the facility had 9 falls for the month of September. Identified falls on the following dates: 9/3/25; 9/4/25; 9/4/25; 9/15/25; 9/24/25, 9/25/25; 9/26/25, 9/27/25; 9/30/25. Noted one resident (R1) had multiple falls since admission. The data documented was inaccurate; the minutes did not identify R1's two falls that occurred on 9/28/25 nor identified that two resident falls occurred on 9/30/25 versus one. Although there was an increase in the number of falls in the month for September, the minutes did not reflect the increased number of falls continued into October one of which resulted in major injury with hospitalization. Although the minutes identified "medical director spoke of starting a fall interdisciplinary team group due to increase in the number of falls this past month and will email to set things up and have a team established" there was no indication the falls were comprehensively analyzed to determine trends and/or possible quality deficits in the fall management program nor was there an action plan developed. During an interview on 10/17/25 at 4:00 p.m., administrator stated the facility did not create an action plan to identify the concern for a sudden jump in falls from August to September. However, the medical director brought up the increase in the number of falls during the 10/9/25 meeting but the quality committee did not analyze or investigate the falls and only talked about making a committee to do this. During an interview on 10/17/25 at 3:45 p.m., director of nursing (DON) stated the facility had seen an increase in the falls from no falls to 8 falls in one month (from August where no falls-to 8 reported falls in the month of September).During the 10/9/25 QAPI meeting the medical director had identified a concern/problem due to sharp increase with falls and recommended the facility add an interdisciplinary team (IDT) fall committee and stated she would be sending some information to the facility with steps to begin this, however, did not formally create action plan to analyze or investigate the increase in falls to identify a quality concern related to falls. Review of the facility's QAPI Change Process Policy undated, identified the facility has established and utilizes a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained.	F0867		

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F0867 SS = F	Continued from page 32 Policy Explanation and Compliance Guidelines: 1. The facility has in operation a Quality Assessment and Assurance (QAA) Committee that is responsible for coordinating and evaluating activities under the facility's QAPI program. 2. The QAA Committee utilizes a systematic approach to performance improvement, including analysis of data, corrective action, and performance tracking. 3. Data analysis – a. The facility draws data from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the QAA committee. b. The QAA committee analyzes the data in order to identify or better understand a problem. c. Once a potential problem is identified, the committee utilizes a systematic approach (e.g., Five Whys, flowcharting, fishbone diagram, Failure Mode and Effect Analysis, etc.) (specify one or more methods) to help identify the root cause of the problem. d. As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes. 4. Corrective action – a. Once the root cause of a problem is identified, the QAA committee oversees the development of an appropriate corrective action. An appropriate corrective action is one that addresses the underlying cause of the issue comprehensively, at the systems level. b. Corrective action plans include: i. A definition of the problem – which includes determining contributing causes of the problem. ii. Measurable goals. iii. Step-by-step interventions to correct the problem and achieve established goals; and iv. A description of how the QAA committee will monitor to ensure changes yield the expected results.			F0867			

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F0867 SS = F	Continued from page 33 c. Example corrective actions may include, but are not limited to: i. Introducing new equipment or products, with staff input, that specifically address the identified problem. ii. Updating policies and procedures. iii. Posting reminders or posters depicting desired behaviors. iv. Providing education and verifying competency following the education. v. Eliminating barriers to following facility policies and procedures. vi. Observing staff members and providing feedback on their performance of new practices. vii. Convening a Performance Improvement Project (PIP) to improve a systematic problem or improve quality in absence of a problem. d. The QAA committee uses the "Plan, Do, Study, Act" (PDSA) cycle of improvement for testing any changes within a PIP. i. Plan: developing a plan related to the change that will be tested ii. Do: carrying out the plan iii. Study: observing and analyzing data collected, learning from any consequences iv. Act: making a decision regarding the change, such as to adopt, modify, or abandon the change and start over e. Multiple PDSA cycles may be implemented until the desired performance goals have been met. 5. The facility must conduct distinct performance improvement projects, based on the scope and complexity of facility services and available resources, identified in the facility assessment. 6. The facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis.			F0867			

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F0867 SS = F	Continued from page 34 7. Performance Tracking – a. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. b. A combination of process and outcome measures are used to measure success following the implementation of change. i. Process measures look at the specific steps in a process that lead, either positively or negatively, to a particular outcome. ii. Outcome measures track results. iii. Performance on the measures is discussed in QAA Committee meetings. Data is analyzed, and the process continues as appropriate. c. At least annually, the facility conducts a self-assessment to determine the facility's performance improvement culture. Corrective action is taken as appropriate.	F0867		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	F880 NA-F was provided with 1:1 reeducation of hand hygiene during toileting/incontinence care. This will be completed by date of compliance. This reeducated included ensuring hand hygiene is completed upon entering and exiting room, and immediately upon removing gloves, including glove removal when moving from work on a soiled body site to a clean body site. Handwashing/Hand Hygiene Policy and Procedure was reviewed and updated on 11/6/2025. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All nursing staff (Licensed Nurses, TMAs, and Nursing Assistants) will be educated on the facility policy Handwashing/Hand Hygiene by compliance date. Education included: ensuring hand hygiene is completed upon entering and exiting room, and immediately upon removing gloves, including glove removal when moving from work on a soiled body site to a clean body site. Education on the policy was initiated on 11/7/25. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. All nursing staff will have a perineal care audit done (this includes hand hygiene and glove changes according to policy) by date of	11/15/2025

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F0880 SS = D	Continued from page 35 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 35 compliance. On-call staff who have not been scheduled to work prior to our compliance date will be completed prior to their next scheduled shift 2) The Director of Nursing will complete audits on 5 random nursing staff weekly for 3 months to ensure nursing staff are performing hand hygiene and glove removal during toileting/incontinent cares according to facility policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of Completion: November 15, 2025	

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F0880 SS = D	Continued from page 36 Based on observations, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 1 of 3 residents (R1) observed for handwashing/hand hygiene during toileting/incontinence care. Findings include: R1’s face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction(stroke). R1’s minimum data set (MDS) dated 9/30/25, identified R1 was dependent for all transfers and toileting, and /was cognitively intact. During an observation and interview on 10/16/25 at 4:11 p.m., R1 informed nursing assistant (NA)-F and registered nurse (RN)-C that she needed to go to the bathroom. NA-F pushed R1 to her room. Upon entering R1’s room, NA-F applied gloves without performing hand hygiene. NA-F used a stand-aide to transfer R1 to the commode; she voided and had a bowel movement. NA-F instructed R1 to stand. Once standing, NA-F used her gloved right hand and wet wipes to clean R1’s bottom from any stool. /Once cleaned, NA-F started to pull up R1’s pants without removing her gloves and perform hand hygiene. When surveyor prompted NA-F to perform hand hygiene, NA-F stated, “I do that once I am done with all of my cares.” NA-F continued to pull R1’s pants up with the same gloved hands used for R1’s peri care. NA-F stated, “My hands are not dirty, because the wipe was between R1’s bowel movement and my glove.” NA-F grabbed R1’s wheelchair by the left arm rest with her right hand and moved it behind R1 so she could sit down. R1 then sat down in the wheelchair. NA-F removed her gloves from both hands, she did not perform hand hygiene prior to folding R1's blanket. After NA-F placed the blanket on the bed, NA-F then washed her hands. During a follow up interview on 10/16/25 at 4:38 p.m., NA-F stated the risk of not removing gloves after performing peri care after a bowel movement could cause anything that was touched with the soiled gloves could be contaminated. During an interview on 10/17/25 at 4:35 p.m., registered nurse (RN)-C stated NA-F should have performed hand hygiene prior to entering R1’s room, before and after removing gloves, and removed her contaminated gloves after performing peri care and performed hand hygiene. During an interview on 10/17/25 at 3:27 p.m., director of nursing (DON) stated her expectation of staff would be to perform hand hygiene before and after any cares, before and after removal of gloves. Gloves should be removed after performing peri		F0880				

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F0880 SS = D	Continued from page 37 care and hand hygiene performed and new gloves applied. Review of Hand Hygiene Policy undated, identified that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is indicated and will be performed when, during resident care, moving from a contaminated body site to a clean body site.			F0880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 4, 2025

Administrator

Green Lea Senior Living

115 North Lyndale, Rr 2 Box 49

Mabel, MN 55954

Re: State Nursing Home Licensing Orders

Event ID: 1D91A2-H1

Dear Administrator:

The above facility survey was completed on October 17, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3B 3rd Floor
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/10/25, 10/14/25, 10/15/25, 10/16/25, and 10/17/25, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.			20000			11/05/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/17/2025	
NAME OF PROVIDER OR SUPPLIER Green Lea Senior Living				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 55954			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
20000	Continued from page 1 The following complaints were reviewed. H55365623C (2638150) with a licensing order issued at 830, 910, 550, 255, and 1375. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.		20000				
20255	Quality Assessment and Assurance Committee CFR(s): MN Rule 4658.0070 A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's		20255	CORRECTED		11/15/2025	

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20255	Continued from page 2 staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI)committee identified, investigated, analyzed, and responded to identified resident care issues by developing and implementing action plans for process improvement identified resident care issues related to high number of falls. This had the potential to affect all 32 residents residing in the facility. SEE F689: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of fall with major injury for 2 of 3 residents (R1, R4) who had falls. This resulted in an immediate jeopardy (IJ) for R1 who sustained a resulted in a subarachnoid hemorrhage (type of brain bleed) and was hospitalized. Review of the QAPI facility minutes for past 6 months identified the following: -5/8/25 QAPI meeting minutes identified two falls for month of April and falls isolated (one with no injury and 1 with minor injury). No trends identified. -6/12/25 QAPI meeting minutes identified one fall for the month of May and fall was isolated and no injury. No trends identified. -7/10/25 QAPI meeting minutes identified two falls for the month of June falls were isolated and one with no injury and one with minor injury. No trends identified. -8/14/25 QAPI meeting minutes identified one fall for the month of July-isolated fall with no injury. No trends identified. -9/11/25 QAPI meeting minutes identified the facility had no falls for the month of August. Review of the facility fall incident reports between		20255				

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20255	Continued from page 3 9/9/25 through 9/30/25 identified there were a total 9 falls. -10/9/25 QAPI meeting minutes identified the facility had 9 falls for the month of September. Identified falls on the following dates: 9/3/25; 9/4/25; 9/4/25; 9/15/25; 9/24/25, 9/25/25; 9/26/25, 9/27/25; 9/30/25. Noted one resident (R1) had multiple falls since admission. The data documented was inaccurate; the minutes did not identify R1's two falls that occurred on 9/28/25 nor identified that two resident falls occurred on 9/30/25 versus one. Although there was an increase in the number of falls in the month for September, the minutes did not reflect the increased number of falls continued into October one of which resulted in major injury with hospitalization. Although the minutes identified "medical director spoke of starting a fall interdisciplinary team group due to increase in the number of falls this past month and will email to set things up and have a team established" there was no indication the falls were comprehensively analyzed to determine trends and/or possible quality deficits in the fall management program nor was there an action plan developed. During an interview on 10/17/25 at 4:00 p.m., administrator stated the facility did not create an action plan to identify the concern for a sudden jump in falls from August to September. However, the medical director brought up the increase in the number of falls during the 10/9/25 meeting but the quality committee did not analyze or investigate the falls and only talked about making a committee to do this. During an interview on 10/17/25 at 3:45 p.m., director of nursing (DON) stated the facility had seen an increase in the falls from no falls to 8 falls in one month (from August where no falls-to 8 reported falls in the month of September).During the 10/9/25 QAPI meeting the medical director had identified a concern/problem due to sharp increase with falls and recommended the facility add an interdisciplinary team (IDT) fall committee and stated she would be sending some information to the facility with steps to begin this, however, did not formally create action plan to analyze or investigate the increase in falls to identify a quality concern related to falls. Review of the facility's QAPI Change Process Policy undated, identified the facility has established and utilizes a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained.			20255			

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20255	Continued from page 4 Policy Explanation and Compliance Guidelines: 1. The facility has in operation a Quality Assessment and Assurance (QAA) Committee that is responsible for coordinating and evaluating activities under the facility’s QAPI program. 2. The QAA Committee utilizes a systematic approach to performance improvement, including analysis of data, corrective action, and performance tracking. 3. Data analysis – a. The facility draws data from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the QAA committee. b. The QAA committee analyzes the data in order to identify or better understand a problem. c. Once a potential problem is identified, the committee utilizes a systematic approach (e.g., Five Whys, flowcharting, fishbone diagram, Failure Mode and Effect Analysis, etc.) (specify one or more methods) to help identify the root cause of the problem. d. As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes. 4. Corrective action – a. Once the root cause of a problem is identified, the QAA committee oversees the development of an appropriate corrective action. An appropriate corrective action is one that addresses the underlying cause of the issue comprehensively, at the systems level. b. Corrective action plans include: i. A definition of the problem – which includes determining contributing causes of the problem. ii. Measurable goals. iii. Step-by-step interventions to correct the problem and achieve established goals; and iv. A description of how the QAA committee will monitor to ensure changes yield the expected results. c. Example corrective actions may include, but are not		20255				

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20255	Continued from page 5 limited to: i. Introducing new equipment or products, with staff input, that specifically address the identified problem. ii. Updating policies and procedures. iii. Posting reminders or posters depicting desired behaviors. iv. Providing education and verifying competency following the education. v. Eliminating barriers to following facility policies and procedures. vi. Observing staff members and providing feedback on their performance of new practices. vii. Convening a Performance Improvement Project (PIP) to improve a systematic problem or improve quality in absence of a problem. d. The QAA committee uses the “Plan, Do, Study, Act” (PDSA) cycle of improvement for testing any changes within a PIP. i. Plan: developing a plan related to the change that will be tested ii. Do: carrying out the plan iii. Study: observing and analyzing data collected, learning from any consequences iv. Act: making a decision regarding the change, such as to adopt, modify, or abandon the change and start over e. Multiple PDSA cycles may be implemented until the desired performance goals have been met. 5. The facility must conduct distinct performance improvement projects, based on the scope and complexity of facility services and available resources, identified in the facility assessment. 6. The facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. 7. Performance Tracking –		20255				

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20255	Continued from page 6 a. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. b. A combination of process and outcome measures are used to measure success following the implementation of change. i. Process measures look at the specific steps in a process that lead, either positively or negatively, to a particular outcome. ii. Outcome measures track results. iii. Performance on the measures is discussed in QAA Committee meetings. Data is analyzed, and the process continues as appropriate. c. At least annually, the facility conducts a self-assessment to determine the facility's performance improvement culture. Corrective action is taken as appropriate.SUGGESTED METHOD OF CORRECTION: The QAPI committee should review and/or revise QAPI policies and procedures to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes for care and quality of life. Data brought forth should have meaningful review of each area noted. QAPI should identify benchmarks and goals, and review data to identify trends, create action plans to achieve their goals, and to monitor facility progress. QAPI should then report those efforts to the Governing Body to monitor for compliance. The administrator will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20255				
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 of 3 residents (R1) reviewed for residents who had falls.		20550	CORRECTED		11/15/2025	

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20550	Continued from page 7 Findings include: R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction (stroke). R1's fall incident report dated 9/26/25 at 2:00 p.m., identified R1 had an unwitnessed fall from wheelchair in room. R1 stated she was trying to get to the bathroom. R1's progress note dated 9/28/25 at 7:17 p.m., indicated R1 fell from bed onto cushioned mat on the floor. R1's progress note dated 9/30/25 at 9:47 p.m., identified R1 had a fall at 8:50 p.m. R1 was found lying on the fall mat next to her bed. R1 had removed brief and only had on gripper sock on. R1's 5-day MDS assessment with an assessment reference date of 9/30/25, identified section J1800 was coded as R1 had not had any falls since admission/entry even though R1's records identified three falls since admission. During an interview on 10/17/25 at 1:04 p.m., Minimum Data Set Coordinator/registered nurse (MDS-RN) stated R1's MDS with an ARD date of 9/30 was not accurate. Section J1800 should have been marked that R1 had falls since admission, however, was marked that R1 did not have any falls since admission. MDS-RN stated that he referenced the Risk Management fall incident reports and reviews the progress notes during the ARD window, however, must have missed seeing R1's falls on 9/29/25, 9/28/25 and 9/30/25. Review of the facility's Resident Assessments Policy dated 10/2023, identified the following: A comprehensive assessment of each resident is completed at intervals designed by OBRA regulations and PPS requirements. Data from the MDS is submitted to the Internet Quality Improvement Evaluation System (IQEIS) as required. Policy interpretation and implementation included the following: SUGGESTED METHOD OF CORRECTION: The Administrator/Director of Nursing or designee should review policies and procedures regarding accuracy of MDS accuracy, train MDS coordinator in ensuring		20550				

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20550	Continued from page 8 information is accurate when coded on the MDS, and implement measures to track the MDS is accurate The facility should ensure staff are competent in fall prevention and protocols. The director of nursing or designee should conduct audits of the delivery of care with falls and fall prevention-risk management, care plans, and root cause analysis and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring.		20550				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of fall with major injury for 2 of 3 residents (R1, R4) who had falls. This resulted in an immediate jeopardy (IJ) for R1 who sustained a fall that resulted in a subarachnoid hemorrhage and was hospitalized. R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction (stroke). R1's hospital discharge summary dated 9/25/25, identified R1 was admitted to the hospital 9/6/25 and discharged to the facility on 9/25/25 with diagnoses that included cerebral vascular accident (CVA), diabetes, and bipolar disorder. The discharge summary indicated R1 required assist of two for activities of daily living and assist of two with total mechanical lift for transfers. R1's Admission Nursing Assessment		20830	CORRECTED		11/15/2025	

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20830	Continued from page 9 dated 9/25/25, identified R1 was alert and orientated to person, but not aware of time and place, used a wheelchair for mobility, had poor trunk control due to right sided deficit from stroke, and surface to surface transfer was not steady and needed staff assistance for transfers. R1's Morse Fall Scale (a tool used to assess a resident risk for falling) dated 9/25/25, identified R1 was moderate risk for falling. R1 had impaired gait and overestimates or forgets limits. There was no further information included. R1's Temporary Care Plan dated 9/25/25, did not identify R1's level of risk for falling as identified in the Morse Fall Scale. R1's care plan identified R1 was assist of two with a full body mechanical lift, R1 was incontinent of bowel and bladder, but did not identify a toileting routine/schedule. Further the care plan did not include any interventions to prevent/reduce falls including applicable interventions associated with R1's fall risk factors identified on the Morse Fall Scale (impaired gait and overestimates or forgets limits). R1's fall incident report dated 9/26/25 at 2:00 p.m., identified R1 had an unwitnessed fall from wheelchair in room. R1 stated she was trying to get to the bathroom. R1 was incontinent of urine, and the floor was wet. Review of facility incident reports and R1's record did not include a comprehensive fall investigation and analysis to determine all potential risk factors for which appropriate interventions would be implemented to prevent/mitigate the risk for falls. Although the progress note indicated one potential causal factor of R1's fall was attempting to use the bathroom, there was no indication R1's care plan was revised to include associated interventions. R1's physical therapy (PT) treatment note dated 9/26/25, identified R1 was impulsive and had decreased alertness and judgement. R1's care plan did not identify R1 was impulsive nor include interventions to decrease the risk of falls related to R1's impulsivity. R1's progress dated 9/28/25 at 2:19 a.m., included R1's bed was kept in low position and fall mat along bedside. R1 was found in bed making squirming movements from her bed to the mat, incontinent of urine, and did not use the call light. Subsequent progress note at 4:26 a.m., identified R1 was found scooting herself from the bed to the floor mat. R1 fall focus care plan initiated on 9/28/25, identified R1 was high risk for falls related to confusion, incontinence, poor communication/comprehension, and unaware of safety needs. R1's "impulsivity" that was documented by PT on 9/26/25 was not included in the listing of risk factors. Interventions included: anticipate and meet the needs of the resident, be sure call light is within	20830		

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20830	Continued from page 10 reach and encourage the resident to use it for assistance, the resident needs prompt response to all requests for assistance, ensure the resident is wearing appropriate footwear and no-skid gripper shoes and/or gripper socks. R1's care plan did not include the interventions of low bed nor the fall mat which were identified in the 9/28/25 at 2:19 a.m. progress note. R1's progress note dated 9/28/25 at 7:17 p.m., indicated R1 fell from bed onto cushioned mat on the floor. Subsequent note at 7:19 p.m. included R1 forgets her physical limitations and attempts to move or stand and cannot support self. No further information was documented. There was no corresponding incident report, no indication of a comprehensive analysis to identify causal factors, and no indication R1's care plan was revised. R1's progress note dated 9/30/25 at 9:47 p.m., identified R1 had a fall at 8:50 p.m. R1 was found lying on the fall mat next to her bed. R1 had removed brief and only had on gripper sock on. R1 was very fidgety and unable to remain still. There was no corresponding incident report, no indication of a comprehensive analysis to identify causal factors, and no indication R1's care plan was revisedR1's minimum data set (MDS) dated 9/30/25 (assessment reference date), identified R1 was cognitively intact, had other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self) that occurred 1 to 3 days, had impairment on one side for upper and lower extremities, was frequently incontinent of bowel and bladder, used a wheelchair, and was dependent for all transfers/toileting. The MDS identified R1 did not have any falls since admission even though R1's record had documented falls on 9/26/25, 9/28/25, and 9/30/25. R1's fall incident report dated 10/1/25 at 8:50 a.m., identified R1 was sitting in the lobby when she leaned too far forward and fell out of her wheelchair. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication R1's care plan was revised. R1's PT treatment note dated 10/1/25 (no time stamp), identified R1 had a fall in the lobby prior to "be treated". PT educated staff on therapy ball R1 used for left upper extremity and added pillow behind back to increase comfort and decrease need to be repositioned. There was no indication R1's care plan was revised to include these recommendations. R1's fall incident report dated 10/3/25 at 9:24 a.m., identified R1 was found on floor between door and bed. R1 had an injury above right eye that was swollen and bleeding, and two skin tears on right forearm. Predisposing factors of restless, gait imbalance, and		20830				

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20830	Continued from page 11 weakness. R1 was sent to emergency department (ED) for evaluation. Report indicated R1 had self-propelled to an area where R1 was not observed by staff. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R1's hospital emergency department (ED) note dated 10/3/25, identified R1 was seen in the ED following an unwitnessed fall in the skilled nursing facility after trying to get out of bed. R1 had a hematoma (a localized collection of blood outside the blood vessels) and a small laceration on the right lateral (side) eyebrow and a skin tear on right forearm and computed topography (CT) of the head showed findings concerning for traumatic subarachnoid hemorrhage and was admitted for observation. R1's therapy recommendation dated 10/3/25 (no time stamp), identified R1 was to have supervision when in wheelchair due to R1 was high fall risk and do not leave in room alone when in wheelchair. There was no indication R1's care plan was revised to include these interventions. During an interview on 10/10/25 at 5:55 p.m., therapy director (TD) stated R1 had been impulsive and had poor safety awareness since admission. TD had communicated this to the nursing staff since admission and placed a sign in R1's room after her fall on 10/3/25 to ensure staff did not leave her alone in her room when she returned from the hospital. R1's hospital discharge summary dated 10/8/25, identified R1 was hospitalized 10/3/25 through 10/8/25 following a fall. R1 was kept for observation and was discharged back to the nursing facility on 10/8/25 at 9:30 a.m. In review of R1's record there was no documentation of what time R1 returned to the facility. There was no indication of revisions to R1's care plan for falls upon re-admission. R1's progress note dated 10/8/25 at 12:03 p.m., identified R1 stays in lobby for staff to keep an eye on her while awake. R1's fall incident report dated 10/8/25 at 1:10 p.m., identified R1 was found lying on the floor in her room off the fall mat. R1 stated she rolled out of bed and just kept rolling and rolling. There was no indication of a comprehensive analysis to identify causal factors was completed and no indication R1's care plan was revised. R1's progress note dated 10/8/25 documented at 9:46 p.m., identified at 4:10 p.m., R1 was observed attempting to stand up from wheelchair in main living area. R1 fell to one knee and staff quickly assisted R1 by lifting her back into her wheelchair. No injury. There was no indication an incident report was completed, no comprehensive analysis, and no indication R1's care plan was revised. R1's fall incident report dated 10/8/25 at 7:15 p.m., identified R1 was found on the floor in the			20830			

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20830	Continued from page 12 main living area. Staff reported hearing R1's head hit the floor. R1 sustained a large skin tear on tip of right forearm. Ambulance called and R1 was transported to ED at 7:50 p.m. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R1's progress note dated 10/8/25 at 11:36 p.m., identified that facility received a call from hospital ED and that R1's "test came back negative" and R1 will be sent back to facility. R1's bed was placed near the nursing station and will plan to always keep R1 in view. R1's MDS dated 9/30/25 triggered the fall Care Area Assessment (CAA) which was signed as completed on 10/8/25, identified R1 had a "potential" (versus actual) problem for falls due to taking high risk drugs (antidepressant). The CAA did not include all of R1's risk factors identified in R1's record nor her seven falls, one which resulted in major injury. R1's progress note dated 10/9/25 at 2:56 a.m., identified R1 arrived back to the facility at 1:50 a.m. Providing 1:1 as able and bed in low position and fall mat. R1's fall focus care plan had been updated on 10/9/25 to the following intervention: R1 needs activities to minimize the potential for fall while providing diversion and distraction. R1 needs to be in common area for supervision and enjoys 1:1 activity and had fidget items to utilize. R1's records were reviewed between 10/9/25 to 10/13/25, it was not evident the 1:1 supervision was implemented with the exception of the mentions in progress note dated 10/9/25 and 10/11/25. The duration of the 1:1's on 10/9/25 and 10/11/25 was not identified. During an observation and interview on 10/10/25 at 10:54 a.m., R1 had a sutured laceration above her right eye and yellowish/green bruise below the eye. Nursing assistant (NA)-E and NA-K were assisting R1 onto a commode. Two signs were placed on the wall near R1's bed that directed "Press the red button if you need help or need to get up." R1 stated the sign meant to remind her to use the call light or to just get up if she needed something." NA-E stated she had heard R1 had fallen a while ago that resulted in her right eye with bruises. NA-E stated she was unaware of what the fall prevention interventions were for R1 because she was in training and had not been shown how to look up the interventions. During an interview on 10/10/25 at 12:03 p.m., registered nurse (RN)-B stated when a resident falls, she would perform range of motion, vitals, and enter the information in the Risk Management tab in the electronic health record (EHR). RN-B was unaware of how to complete a fall causal analysis, nor did she know how to add/update a resident's care plan. RN-B explained floor nurses did not complete causal analysis nor update the care		20830				

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20830	Continued from page 13 plans, management would perform those tasks. During an interview on 10/10/25 at 4:20 p.m., NA-G stated R1 would self-transfer since admission. R1’s fall prevention interventions were a low bed with a fall mat on the floor. NA-G was not sure how other staff would know R1 needed those. NA-G stated R1 had been on 1:1 supervision for a short time but was not sure if they had stopped or if that was ongoing. Staff try and ‘keep eyes’ on R1 when she is in her wheelchair, but “sometimes we get busy and may not watch her as close as we should.” NA-G could not articulate any additional fall prevention interventions for R1 and stated she would have to reference a nursing assistant communication book that had each resident's care plan in it, however, was not able to find a care plan for R1 in the book. During an interview on 10/10/25 at 5:25 p.m., director of nursing (DON) stated R1 was a high fall risk upon admission due to not being aware of her own limitations. DON reviewed R1’s fall documentation since admission. DON stated none of R1’s falls included a comprehensive investigation and causal analysis. R1’s care plan had not been revised after each fall and not all interventions documented in the record were represented on the care plan. During an interview on 10/14/25 at 2:53 p.m., trained medication aide (TMA)-C stated he was unaware of all the fall prevention interventions the facility was doing for R1. He was not able to locate the Kardex in R1’s electronic health record and stated the only fall intervention he was aware of was to keep R1 in eyesight when she is up in her chair. TMA-C stated they try to do this as “best they can.” During an interview on 10/14/25 at 3:01 p.m., nursing assistant (NA)-J could not articulate what the fall prevention interventions were for R1. NA-J stated normally there was a book with the Kardex in it and this would tell staff what the fall interventions would be, however, NA-J could not find R1 in the book. NA-J stated she would then go to the kardex/care plan in the EHR (electronic health record) to determine fall prevention interventions, however, upon looking at R1’s kardex/care plan she only identified that R1’s call light should be within reach. The immediate jeopardy that began on 9/26/25, was removed on 10/17/25 at 2:50 p.m., when it was verified, the facility implemented the following: -R1 had an updated fall risk assessment completed. -R1’s falls since admission had a root cause analysis and appropriate fall prevention interventions added to the clinical chart. - Interdisciplinary team met and reviewed R1’s falls and root cause analysis to ensure appropriate fall interventions in place based on resident needs and resident’s status based on the individual falls and			20830			

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20830	Continued from page 14 root cause analysis. -R1's care plan updated to include current fall interventions and fall risk level. -All high risk fall residents who had a fall in the past 30 days had a root cause analysis completed and care plans were updated to remove/negate the risk of falls based on potential risks of falls. -Staff were re-educated on the facility's falls and fall risk, managing, fall risk assessment, assessing falls and their causes, falls-clinical protocol, baseline care plan, and comprehensive care plan policies. -All clinician staff was re-educated on the facility policies, ensuring licensed staff adding immediate intervention post fall, updating care plan, -Agency nursing staff orientation checklist update to include education on fall prevention policies and procedures. R4 R4's face sheet dated 10/16/25, identified diagnoses of Huntington's disease (a rare neurodegenerative disorder that causes progressive physical, cognitive, and psychiatric symptoms), muscle weakness, and history of falling. R4's Admission Minimum Data Set (MDS) dated 8/27/25, identified R4 was cognitively intact, continent of bowel and bladder, needed moderate assistance for transfers, and had a fall in the last month prior to admission. R4's Morse Fall Scale dated 8/26/25, identified R4 was high risk for falling due to weak gait; overestimates or forgets limits. R1's Morse Fall Scale did not identify any further information. R4's fall focus care plan dated 9/5/25, identified R4 was high risk for falls. Goal was that R4 would not sustain serious injury. Interventions included: anticipate needs; be sure call light is within reach; ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R4's fall incident report dated 9/4/25 at 8:36 p.m., identified R4 had an unwitnessed fall and was found on knees with them under the bed holding onto the railing. R4 stated she pushed herself back to her room after the tractor pull and just wanted to go to bed but could not reach the call light. R4 was incontinent of urine at the time of the fall. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R4's fall incident report dated 10/2/25 at 6:40 p.m., identified R4 was self-transferring from wheelchair to the bathroom with walker and slipped out of wheelchair. Vital signs taken and assisted from ground. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R4's fall	20830					

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20830	Continued from page 15 incident report dated 10/14/25 at 7:15 p.m., identified R4 was found in room with bottom on the floor, back to bed, and legs straight out towards door. R4 stated she was going to the bathroom. There was no indication of a comprehensive analysis to identify causal factors and no indication R1's care plan was revised. R4's fall focus care plan was updated on 10/15/25 to include fall prevention intervention to toilet every two hours while awake and after all meals. However, R4's Treatment Administration Record (TAR) identified R4 was to be checked on every hour beginning on 10/15/25 at 1:00 p.m., due to R1 having recent falls. R4's fall incident report dated 10/15/25 at 8:05 p.m., identified R4 was found on her bottom scooting to the toilet. R4 was using hands on the ground to propel herself, knees bent with feet on the floor, and bottom on the ground. R4 stated, "I was crawling to the bathroom and did not want to pee the bed." R4's incident report did not specify when R4 was toileted last. There was no immediate intervention identified and no indication of a comprehensive analysis to identify causal factors until 10/16/25 at 10:51a.m. During an interview on 10/17/25 at 3:05 p.m., DON stated R4's falls had not been comprehensively assessed or had any causal analysis completed for the falls prior to 10/15/25 to ensure the appropriate fall prevention interventions were in place. Review of the facility's Fall and Fall Risk, Managing Policy dated 10/15/25, identified the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk: The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period, as needed. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of	20830		

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20830	Continued from page 16 the falling is identified as unavoidable. Staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling, as appropriate. Position-change alarms may be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Fall Risk: If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls, as needed. Documentation: - The licensed nurse shall promptly initiate and document the accident or incident. - Licensed nurses will update the care plan with the new fall intervention post fall. - Licensed nurse will update the resident's Kardex with fall intervention. - Licensed nurse will document the new fall intervention in the nursing communication binder for clinical staff to review. - Licensed nurse will complete a Morse Fall Scale with each new fall. -IDT will meet on every business day to review resident falls and interventions. Progress note will be made in the residents' record of this review.SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained on fall prevention and protocols. The facility should ensure staff are competent in fall prevention and protocols. The director of nursing or designee should conduct audits of the delivery of care with falls and fall prevention-risk management, care plans, and root cause analysis and competencies are performed. The results of those audits should be taken to QAPI to		20830				

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20830	Continued from page 17 determine compliance or the need for ongoing monitoring.		20830				
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days.						
20910	Rehab - Incontinence CFR(s): MN Rule 4658.0525 Subp. 5 A.B Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure received appropriate treatment and services to prevent decline in incontinence and urinary symptoms and further failed to develop and implement an individualized toileting program for 1 of 1 resident (R4) who had a diagnoses of Huntington's disease, was continent upon admission, but had fluctuating symptoms of incontinence, urgency, and frequency. Findings include: Urge Incontinence is associated with detrusor muscle over activity resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full). It is characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). The resident can feel the need to void but is unable to inhibit voiding long enough to reach and sit on the commode. It is the most common cause of urinary incontinence in elderly persons. " Stress Incontinence is associated with impaired urethral closure which allows small amounts of urine leakage when intra-abdominal pressure on the bladder is		20910	CORRECTED		11/15/2025	

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20910	Continued from page 18 increased by sneezing, coughing, laughing, lifting, standing from a sitting position, climbing stairs, etc. Mixed Incontinence is the combination of urge incontinence and stress incontinence. Many elderly persons (especially women) will experience symptoms of both urge and stress. " Overflow Incontinence is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended from urine retention. Symptoms of overflow incontinence may include: weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. Functional Incontinence refers to loss of urine that occurs in a resident whose urinary tract function is sufficiently intact that he/she should be able to maintain continence, but who cannot remain continent because of external factors other than inherently abnormal urinary tract function. Examples may include inability to get to the bathroom on time, Physical weakness or poor mobility/, Environmental impediments including excessive distance from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access. R4's face sheet dated 10/16/25, identified diagnoses of Huntington's disease (a rare neurodegenerative disorder that causes progressive physical, cognitive, and psychiatric symptoms), muscle weakness, and history of falling. R4's continence evaluation assessment dated 8/27/25, identified R4 had history of incontinence of bladder which was a gradual onset. Symptoms over past 6 months were improving where R4 had one accident per week. The assessment did not identify or include additional information pertaining when and under what if any circumstances led to the incontinence, does not identify the type of incontinence, and does indicate interventions and/or treatments that had improved the incontinence. The assessment also included R4 had some leakage coded as "soil/wet underwear only". R4 did not symptoms of urge incontinence and did not have symptoms of stress incontinence. R4 was aware of the urge to void and on average she was able to hold on after feeling the urge to void for more than 5 minutes. In the section Overflow Incontinence, the coded answers identified R4 felt her bladder was emptying completely, she was aware when urine was being passed, no issues with starting or passing urine, and no dribbling after		20910				

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20910	Continued from page 19 passing urine. R4 was "occasionally aware she was wet" which was not further assessed to determine the type of incontinence that would contribute to wetness without R4's awareness. The assessment also identified R4 had mixed incontinence even though the assessment identified she did not have symptoms of stress and urge incontinence. R4's risk factors for bladder incontinence included diagnosis of cognitive impairment (not listed on diagnosis list), Huntington's disease, prescribed antipsychotic, and required one staff assistance with walker. Not applicable was marked for "voiding record initiated" however did not identify what R4's routine voiding patterns were. The summary section was blank. R4's Admission Minimum Data Set (MDS) dated 8/27/25, indicated R4 did not have cognitive impairment. R4 required moderate assistance for toilet transfers, continent of bowel and bladder, and had intact cognition. Review of R4's Point of Care (POC) task documentation of bladder continence from dates 8/26/25 through 9/3/25- identified R4 was continent of bladder. R4's progress notes reviewed from between 8/26/25 through 9/4/25 identified R4 was continent of bowel and bladder; progress notes did not indicate any concerns or changes in voiding patterns or urinary function. R4's physician visit dated 9/4/25 identified reason for visit was new admission. R4 was admitted to the facility after a fall at home and required hospitalization where she was found to have cystitis (urinary tract infection-UTI).and was treated with antibiotics. The visit did not address and/or mention status of incontinence. R4's progress note dated 9/6/25 at 5:20 a.m. included R4 is having an increase in urinary urgency, she was unable to void but reports the urge to. Denies dysuria. No back or flank pain. Urine is normal and without any concerns. Nursing staff report new onset urinary incontinence within the last day for unknown reason. Continent tonight. Progress note at 1:13 p.m. indicated R1 requested toileting often not always able to void and was occasionally incontinent of urine. R4's progress note dated 9/7/25 indicated R4 was occasionally incontinent of urine but verbalizes toileting needs. R4's progress note dated 9/8/25 indicated R4 used the call light 5 times to request toileting assistance. Continues to have urinary urgency. Voiding amount		20910				

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20910	Continued from page 20 minimal each time. Urine appearance is normal. R4's Care Area Assessment (CAA) signed 9/8/25, identified a potential problem triggered for urinary incontinence. Modifiable risk factors included pain, urinary tract infection, and restricted mobility. Medications included anticholinergics and antipsychotics. The objective for care planning was to minimize risk of incontinence. due to needing assistance with toilet use and/or perineal cares during the assessment period. No other information was included. R4's POC documentation indicated R4 had a change in continence on 9/4/25. Documentation identified incontinent episodes on 9/4/25, 9/5/25, 9/6/25, 9/8/25, 9/10/25, 9/12/25, 9/13/25, and 9/14/25. R4's POC documentation between 9/15/25 through 9/22/25, identified R4 did not have incontinence. R4's progress notes reviewed 9/9/25 between 9/22/25, identified R4 was continent of bladder ten days (9/9/25, 9/10/25, 9/11/25, 9/13/25, 9/14/25, 9/15/25, 9/16/25, 9/17/25, 9/18/259/19/25, and 9/22/25) and had frequency on 9/12/25, 9/14/25 and 9/18/25 (frequency and burning with urination). R4's physician visit dated 9/22/25 indicated R4 was seen for urinary frequency and some episodes of urinary incontinence, treated for a UTI when she was hospitalized and has urinary frequency here. Staff feel like the frequency is getting worse. R4 denies any burning or pain. She is not sure if she has really noticed the urinary frequency and there is "nothing wrong". The physician ordered a urine analysis. R4's progress note dated 9/24/25 included did not show infection. R4's POC documentation between 9/23/25 through 10/4/25 R4 did not have any incontinent episodes except on 9/24/25, 9/29/25, 10/1/25, 10/2/25, and 10/4/25 with other days between R1 was continent of urine. R4's POC documentation between 10/5/25 through 10/11/25, identified R4 did not have any incontinent episodes. Between 10/12/25 through 10/17/25, identified R4 had episodes of incontinence on 10/12/25, 10/13/25, 10/14/25 and 10/15/25. R4's progress notes 9/23/25 through 10/17/25, identified R4 was continent of urine on 9/25/25, 9/26/25, 9/27/25, 9/28/25, 9/29/25, and 9/30/25. R4 had episodes of needed to urinate frequently (every 30		20910				

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NAME OF PROVIDER OR SUPPLIER Green Lea Senior Living				STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH LYNDALE, RR 2 BOX 49 , MABEL, Minnesota, 55954			
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20910	Continued from page 21 minutes to 1 hour) on 9/24/25 and 10/15/25. Review of R1's care plan indicated it was not initiated until 10/1/25 even though the CAA's were signed on 9/8/25. Further the care plan did not include a focus area that addressed R1's urinary continence that included goals and interventions that would prevent decline in bladder incontinence and/or maintain in addition to manage R4's urinary symptoms. R4's activities of daily living (ADL) focus care plan, initiated on 10/1/25, identified R4 had a self-performance deficit related to confusion, impaired balance, and Huntington's Disease. Corresponding interventions included: dependent on staff for transferring with gait belt and walker, transfer to toilet with assist of one and able to wipe herself after she is done. R4's care plan did not identify an individualized toileting plan. R4's fall focus care plan identified a new intervention on 10/15/25 to toilet every two hours while awake and after each meal however R4's record did not include a corresponding comprehensive bladder assessment and/or voiding diary that identified how that toileting schedule was determined. In review of R4's revealed although incident reports identified R4 had four falls (9/4/25, 10/2/25, 10/14/25, and 10/15/25) in which documentation indicated toileting as a causal factor there was no indication of a comprehensive bladder assessment was completed to determine type and/or possible changes in bladder function. Additionally, there was no indication of assessment to determine an appropriate toileting program/schedule. During an observation and interview on 10/17/25 at 8:30 a.m., R4 stated staff did not offer to take her to the bathroom regularly and further stated "they think I only need to go once per day, but I need to go more than that. Sometimes I pee the chair, recliner, and bed. This makes me feel terrible and like a baby." R4 then began to cry and stated, "Sometimes I cannot find the call light and just have to try and take myself to the bathroom, but I fall when I try and I just want to be able to able to keep my bladder control like I did when I first came." During an interview on 10/16/15 at 9:22 a.m., licensed practical nurse (LPN)-A stated that the standard for toileting people is that all residents are toileted every two hours. LPN-A was unsure how staff were keeping track of how often residents were toileted. R4 did not have a toileting plan in place prior to 10/15/25. During an interview on 10/10/25 at 4:20 p.m., nursing		20910				

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20910	Continued from page 22 assistant (NA)-G stated staff tried to toilet every resident every two hours. NA-G was not aware if R4 had a different toileting schedule. NA-G stated R4 had been having more incontinent episodes lately. R4 would normally ask for assistance to use the bathroom however would attempt to take herself at times. During an interview on 10/17/25 at 3:35 p.m., director of nursing (DON) stated R4 was continent on admission and did have a toileting schedule added to her care plan on admission. DON reviewed R4's record, she explained the documentation identified R4's incontinence had worsened to frequently incontinent of urine. DON thought the increase in incontinence was because staff were not aware of how often R4 should be toileted. Review of the facility's Incontinence Policy undated, identified the facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with incontinence and ensure that a comprehensive assessment is completed and toileting schedule to ensure the resident maintains bowel and bladder function. The director of nursing or designee, could conduct random audits of assesments, care plan, and toileting schedules to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		20910				
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 1 of 6 residents (R1) observed for handwashing/hand hygiene during		21375	CORRECTED		11/15/2025	

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21375	Continued from page 23 toileting/incontinence care. Findings include: F880R1's face sheet dated 10/15/25, identified diagnoses of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (partial weakness on one side of the body making it difficult to perform daily activities) following cerebral infarction(stroke). R1's minimum data set (MDS) dated 9/30/25, identified R1 was dependent for all transfers and toileting, and /was cognitively intact. During an observation and interview on 10/16/25 at 4:11 p.m., R1 informed nursing assistant (NA)-F and registered nurse (RN)-C that she needed to go to the bathroom. NA-F pushed R1 to her room. Upon entering R1's room, NA-F applied gloves without performing hand hygiene. NA-F used a stand-aide to transfer R1 to the commode; she voided and had a bowel movement. NA-F instructed R1 to stand. Once standing, NA-F used her gloved right hand and wet wipes to clean R1's bottom from any stool. /Once cleaned, NA-F started to pull up R1's pants without removing her gloves and perform hand hygiene. When surveyor prompted NA-F to perform hand hygiene, NA-F stated, "I do that once I am done with all of my cares." NA-F continued to pull R1's pants up with the same gloved hands used for R1's peri care. NA-F stated, "My hands are not dirty, because the wipe was between R1's bowel movement and my glove." NA-F grabbed R1's wheelchair by the left arm rest with her right hand and moved it behind R1 so she could sit down. R1 then sat down in the wheelchair. NA-F removed her gloves from both hands, she did not perform hand hygiene prior to folding R1's blanket. After NA-F placed the blanket on the bed, NA-F then washed her hands. During a follow up interview on 10/16/25 at 4:38 p.m., NA-F stated the risk of not removing gloves after performing peri care after a bowel movement could cause anything that was touched with the soiled gloves could be contaminated. During an interview on 10/17/25 at 4:35 p.m., registered nurse (RN)-C stated NA-F should have performed hand hygiene prior to entering R1's room, before and after removing gloves, and removed her contaminated gloves after performing peri care and performed hand hygiene. During an interview on 10/17/25 at 3:27 p.m., director of nursing (DON) stated her expectation of staff would be to perform hand hygiene before and after any cares, before and after removal of gloves. Gloves should be removed after performing peri care and hand hygiene performed and new gloves applied. Review of Hand Hygiene Policy undated, identified that all staff will perform proper hand hygiene procedures		21375				

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21375	Continued from page 24 to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is indicated and will be performed when, during resident care, moving from a contaminated body site to a clean body site. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct hand hygiene when assisting residents in the dining room. The DON or designee could review and revise dining policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.		21375				