DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 17, 2023

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

RE: CCN: 245536
Cycle Start Date: September 20, 2023

Dear Administrator:

On October 26, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 5, 2023

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

RE: CCN: 245536
Cycle Start Date: September 20, 2023

Dear Administrator:

On September 20, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 20, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 20, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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October 5, 2023

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

Re: Event ID: T32F11

Dear Administrator:

The above facility survey was completed on September 20, 2023, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	C 09/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/19/23 to 9/20/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H55365485C (MN00096714) with deficiencies issued at F602; H55365723C (MN00095780) with no deficiency issued. As a result of the investigation deficiencies were also issued at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 602		10/13/23

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

Electronically Signed | 10/13/2023

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

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F 602	Continued From page 1 treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to secure a narcotic medication which was delivered without a corresponding medication order, and facility failed to investigate circumstances surrounding lost narcotic and implement action plan to prevent potential reoccurrence for 1 of 1 resident (R1) reviewed for drug diversion. Findings include: R1's quarterly Minimum Data Set (MDS), dated 6/29/23, indicated an intact cognition. The MDS indicated R1 had occasional mild pain and received scheduled pain medication. The progress notes showed on 8/26/23, R1 rated hip pain at 10/10 despite oral medication and topical application of ice pack to area. The progress notes indicated R1 was transported to the hospital's emergency department at 4:30 p.m. and returned at 9:30 p.m., with an order for hydrocodone-acetaminophen 5-325 milligrams (mg) 1 tablet every six hours as needed for pain times three days. The progress notes further indicated the order for hydrocodone was sent to pharmacy. However, the progress notes did not indicate if the facility verified this order with pharmacy. The pharmacy packing slip dated 8/28/23, showed facility received 10 tablets of oxycodone 5 mg at the facility, as indicated by registered nurse (RN)-A's signature. R1's medication administration record (MAR) for	F 602	F 602 PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 602, Free from Misappropriation/Exploitation, Green Lea Senior Living corrected the deficiency by ensuring narcotic medication for R1 and all like residents were reconciled by 9/11/2023 by the Director of Nursing. On 9/11/2023 the Director of Nursing started auditing all narcotics that arrive from pharmacy by reviewing medication packing slip to ensure there is an order from the physician, order is transcribed in Point Click Care, and medication order/amount is accurate on narcotic	

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F 602	Continued From page 2 the month of August 2023, indicated an order for hydrocodone-acetaminophen 5-325 mg 1 tab every 6 hours as needed for pain times three days (8/26/23 through 8/29/23). The MAR indicated R1 did not receive any dose of hydrocodone. The MAR also did not indicate an order for oxycodone 5 mg and the MAR did not indicate R1 received any oxycodone. Multiple staff interviews showed conflicting accounts about the oxycodone but consistent in statements indicating the facility lacks a system to secure narcotics, as follows: -During interview on 9/19/23 at 10:09 a.m., RN-A verified receiving 10 oxycodone 5 mg tablets for R1 on 8/28/23. RN-A stated she "looked briefly" and there was no order for the oxycodone but that the prescriber's name matched that of the doctor who saw R1 at the hospital emergency department. RN-A stated it was already "late at night" so she passed on report to the overnight nurse to review the orders and medications. RN-A stated she did not know facility policy on what to do with the medication received without an order. RN-A stated she verified the correct number with the overnight nurse (RN-B), and then put the medication in the narcotic box. RN-A also stated when she returned to work three days later, on 8/31/23, and observed the oxycodone tablets were still in the narcotic box. RN-A stated she thought of checking for the oxycodone on 8/31/23 because of the lack of order but when she saw the medication remained in the narcotic lock box, she "assumed the orders were OK" and did not investigate further. RN-A stated when she returned to work on 9/4/23, she saw a "notation" that the oxycodone was missing. RN-A stated, "I didn't realize it was gone. I wish I did a little bit of	F 602	inventory sheet. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on process for receiving medications from pharmacy and counting narcotics by 10/13/2023 by the Director of Nursing. The Director of Nursing and/or designee will audit pharmacy delivery sheets for narcotics weekly for 3 months and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit narcotic counts 2x/week for 3 months and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community□s QA Process.	

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F 602	Continued From page 3	F 602		

investigating then. It did not strike as concerning to me."

-During interview on 9/19/23 at 10:34 a.m., treatment medication aide (TMA)-A stated she saw the oxycodone when counted with RN-A on 8/31/23 at 2:00 p.m., and that was the last shift she worked as TMA. TMA-A stated, "Narcs [narcotics] is one thing I do not like working as a TMA at [facility]" because the facility does not have a good process by allowing TMAs to handle narcotics. TMA-A stated the change was to have nurses count narcotics but then added, "I wish they have a better process; I am not really involved."

-During interview on 9/19/23 at 11:32 a.m., licensed practical nurse (LPN)-A verified working day shifts on 9/2/23 through 9/4/23 but did not count narcotics as it was then the TMA who counted with the off going nurse and then with the oncoming nurse. LPN-A stated she only learned about missing oxycodone on 9/4/23, when the overnight nurse, RN-C, was looking for it. LPN-A also stated she looked in R1's medication orders and did not see oxycodone. LPN-A stated RN-C called the director of nursing (DON) that morning on 9/4/23, and then "it was on her [DON's] hands." LPN-A stated they implemented a change making three staff members to count which would include the oncoming nurse and oncoming TMA and the off-going nurse to count at 6:00 a.m., and then again at 2:00 p.m. with the off going nurse, the oncoming nurse, and the TMA. LPN-A stated she had "mixed feelings" whether that new narcotic counting process would help prevent drug diversion. LPN-A stated staff would still not notice narcotics that go missing when the narcotic sheet and the medication are both gone.

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F 602	Continued From page 4 -During interview on 9/19/23 at 1:21 p.m., TMA-B stated on 8/31/23, therapy staff asked her to give R1 pain medication, and when she checked R1's medication orders, she saw tramadol and so that was what she gave. However, review of R1's MAR for 8/31/23 lacked evidence to show TMA-B administered tramadol to R1 on 8/31/23. TMA-B also stated there was no oxycodone, and only the tramadol was in stock as R1's narcotics in the locked box on 8/31/23. TMA-B stated implementing the new process to have three sets of eyes versus two would help. However, TMA-B illustrated in an example that if the narc sheet was filled out and would be taken away or given to the DON and then no new sheet was started; or if a narcotic sheet was taken out of the narcotic book and the med card was also taken out from the narcotic box, no one would never know that the narcotic was there. TMA-B stated, "[It] would not be discovered that it went missing." -During interview on 9/19/23 at 1:44 p.m., LPN-B acknowledged the facility's implementation of new system to count and verify orders for narcotics wherein "another set of eyes" would be there during narcotic counting and pharmacy packing slips will now go to the DON for her to verify medications (narcotics) that arrive were correct orders. LPN-B stated, "I'm not sure how we would know [missing narcotic] if the sheet and meds are gone." -During interview on 9/19/23 at 2:17 p.m., RN-C stated she last saw R1's oxycodone in the morning of 9/2/23 (Saturday), and it was still full. RN-C stated in the morning of 9/3/23 (Sunday), she counted with TMA-B but TMA-B already started counting the narcotics and went past R1's	F 602		

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F 602	Continued From page 5 section. RN-C stated she did not actually see if the oxycodone was in the narcotic box. RN-C also stated when she returned to work that night (10:00 p.m.) on 9/3/23, she did not actually do narcotic counting with LPN-D. However, when she counted with TMA-C in the morning of 9/4/23, she realized that R1's oxycodone was missing. RN-C stated she looked for the oxycodone because it was delivered without an order and that she had previously seen it on 9/2/23. RN-C stated she went to look for the pharmacy packing slip and verified there was oxycodone received at the facility. RN-C stated she reported that the oxycodone was missing to the DON at about 6:30 a.m. on 9/4/23. -During interview on 9/19/23 at 4:11 p.m., LPN-C stated she worked one day every other weekend, however, could not remember seeing the oxycodone during the count saying, "There's a lot of narcotics there." LPN-C stated the new policy now would be to do 3 counts during the day shift, at 6:00 a.m., at 2:00 p.m., and at 6:00 p.m. LPN-C further stated, "Honestly, it's not gonna help. It does not matter." LPN-C said nobody talked to her about what happened and what should have been done or what to do to prevent the same incident from happening again. During interview on 9/19/23 at 1:51 p.m., the consultant pharmacist (CP) stated, during his "visit at the end of August" the staff talked about medication received in error and stated that he was told the medication was sent back to the pharmacy. The CP stated that the facility does not have a process in place for an "extremely unusual thing" such as medication erroneously delivered. The CP added, "However, they are expected to do something similar to when somebody dies,	F 602		

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F 602	Continued From page 6	F 602		

narc meds are destroyed, and there should be two nurses to do that." The CP also stated the process was similar if a narcotic was received erroneously that "they should still add to the narcotic book and signed out when destroyed, sent back or whatever they did with it." The CP further stated expectations that all narcotics should be accounted for and documented.

During interview on 9/19/23 at 3:02 p.m., the DON stated that her investigation findings showed staff had inconsistent versions of when they last saw the oxycodone, and it was only on 9/1/23 (Friday) that there were "two sources" or staff members who verified seeing the oxycodone. The DON concluded it got lost after 9/1/23 because even though one staff member also claimed seeing it on 9/2/23 (Saturday), the other staff member who worked during that time did not see it. The DON acknowledged that facility lacked a system to monitor or to keep track of narcotics from acquisition to disposition. The DON acknowledged lack of thorough investigation to find out what was missed and how the narcotic should have been managed to prevent it from getting lost.

During interview on 9/20/23 at 11:34 a.m., the administrator indicated the oxycodone tablets remain unaccounted for and acknowledged that the facility did not re-educate staff regarding management of narcotics delivered to the facility in error, as well as, how to ensure security of narcotics from the time they are received until properly disposed.

The policy titled, Medication Ordering and Receiving from Pharmacy, revised in 1/18, provides that a licensed staff member verifies

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F 602	Continued From page 7 medications in the medication order form, promptly reports discrepancies to the issuing pharmacy, and appropriately secures the medication. The policy provides that a licensed or certified staff member reconciles controlled substance orders against what has been received from the pharmacy; and notifies pharmacist if controlled substance orders are incorrect. The policy directs two licensed or certified staff members witness placement of the controlled substances in the secured compartment of the medication cart. The policy further provides that controlled substance inventory sheets are completed and filed appropriately, and a logbook is utilized to track the controlled substance from delivery to disposition. The policy titled, Discrepancies, Loss, and/or Diversion of Medications, revised in 11/18, provides that all discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed. The policy provides that upon discovery of the suspected loss or diversion, the administrator, the director of nursing, and the consultant pharmacist are notified, and an investigation conducted. In the case of loss of a supply of medication, a search for the medication and investigation must be completed, and all the drug accountability procedures and documentation should be reviewed and audited.	F 602		
F 609 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:	F 609		10/13/23

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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
F 609	Continued From page 8 §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: Based on interview and records review, the facility did not report allegation of drug diversion in a timely manner for 1 of 1 resident (R1) reviewed for medication management. Findings include: R1's quarterly Minimum Data Set (MDS), dated 6/29/23, indicated an intact cognition. The MDS indicated R1 had occasional mild pain and received scheduled pain medication. The progress notes dated 8/26/23, indicated R1 requested to be sent to the emergency	F 609	F 609 PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	C 09/20/2023

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F 609	Continued From page 9 department (ED) related to hip pain, which she rated at 10/10. The ED visit summary notes dated 8/26/23, indicated an order for R1 to start hydrocodone-acetaminophen 5-325 milligram (mg), also known as Norco, one tablet every six hours as needed for pain times three days. However, the pharmacy packing slip dated 8/28/23, indicated pharmacy delivered to the facility and registered nurse (RN)-A received 10 tablets of 5 mg oxycodone for R1 instead of Norco. During interview on 9/19/23 at 10:09 a.m., RN-A verified receiving 10 tablets of 5 mg oxycodone for R1 on 8/28/23. RN-A stated there was no order for the medication, but she and RN-B verified the correct number of tablets and stored the medication in the narcotic locked box. RN-A stated the last time she saw the medications was on 8/31/23. RN-A stated when she returned to work on 9/4/23, she learned that the oxycodone could not be found. During interview on 9/19/23 at 2:17 p.m., RN-C stated when she did narcotic counting with TMA-C in the morning of 9/4/23, she realized that R1's oxycodone was missing. RN-C stated she looked for the oxycodone because it was delivered without an order and that she had previously seen it on 9/2/23. RN-C stated she went to look for the pharmacy packing slip and verified there was oxycodone received at the facility. RN-C stated she reported the missing oxycodone to the DON at about 6:30 a.m. on 9/4/23.	F 609	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 609, Reporting of Alleged Violations, Green Lea Senior Living corrected the deficiency by educating the Executive Director and the Director of Nursing on reporting alleged violations in a timely manner for R1 and all like residents by the Regional Clinical Nurse Specialist on 10/11/2023. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on the Vulnerable Adult Policy on 10/13/2023 by the Director of Nursing. The Executive Director and/or designee will audit 3 staff members on the Vulnerable Adult Policy to ensure timely reporting of alleged violations weekly for 3 months and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community□s QA Process.	

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F 609	Continued From page 10 During interview on 9/19/23 at 3:02 p.m., the DON stated she became aware about R1's oxycodone on 9/4/23 in the morning. The DON stated she was at home at that time and checked R1's medication orders but did not find oxycodone, and because it was a holiday pharmacy was closed, so she decided to wait until 9/5/23 to call the pharmacy and verified pharmacy delivered oxycodone for R1. The DON stated she then started her investigation and received conflicting statements from staff about when they last saw the oxycodone. The DON stated that it was only on 9/1/23, where she had two staff verifying, they saw the narcotic. The DON concluded the oxycodone was missing since 9/1/23, and then reported it to the administrator during stand-up on 9/5/23. The DON stated she did not report immediately to the administrator on 9/4/23 because she still did not know if it was missing. During interview on 9/20/23 at 11:34 Am, the administrator she learned about the "medication issue" on 9/5/24 but did not do her report yet at that time because they still did not know if there was indeed a missing narcotic. The administrator verified it was until they confirmed the medication could not be found that she made her report on 9/6/23 at 1:28 p.m. The policy titled, Discrepancies, Loss and/or Diversion of Medications, revised on 11/18, provides that all discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed. The policy provides that immediately upon discovery or suspicion of a discrepancy, suspected loss or diversion, the administrator, director of nursing, consultant	F 609		

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F 609	Continued From page 11 pharmacist, are notified and an investigation conducted. The policy further provides that for loss of a supply of medication, appropriate agencies, required by state and federal law, will be notified. The policy titled, Vulnerable Adult, updated on 10/19/22, notes that facility supports "Zero Tolerance" for resident abuse, neglect, mistreatment, and/or misappropriation of resident property. The policy provides that all alleged violations will be reported no later than 24 hours if the events that cause the suspicion does not involve abuse and does not result in serious bodily injury. The policy provides that everyone having knowledge of the criminal act has duty to report to law enforcement and the state agency. The policy lists examples of situations that would be considered crimes include theft, and drug diversion for personal use or gain.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		10/13/23

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F 610	Continued From page 12 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not evaluate training program and re-train staff regarding allegations of verbal abuse for 1 of 1 residents (R2) reviewed for verbal abuse. Findings include: R2's significant change MDS dated 6/8/23, showed intact cognition, and indicated no behaviors. The MDS listed R2's active diagnoses, including stroke, pneumonia, diabetes mellitus, and depression. R2's care plan indicated communication deficit related to minimal hearing loss. The care plan directed staff to encourage R2 to continue stating thoughts even if he is having difficulty, and respond to the feeling resident is trying to express; to observe and document frustration level and wait 30 seconds before providing with word; and to use communication techniques which enhance interaction, and clarify to ensure understanding. The careplan also indicated R2 a vulnerbale adult and susceptible to abuse. The careplan directed staff to ensure R2 was in a safe environment. During interview on 9/20/23 at 8:13 a.m., treatment medication aide (TMA)-A indicated an incident when she was working with R2 and TMA-D spoke to R2 inappropriately. TMA-A stated they did not report it immediately to the administrator at that time because they were	F 610	F 610 PLAN OF CORRECTION Green Lea Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 610, Investigate/Prevent/Correct Alleged Violation, Green Lea Senior Living corrected the deficiency by educating the Executive Director and the Director of Nursing on ensuring all alleged violations are investigated thoroughly and interventions are put into place to prevent/correct alleged violations for R2 and all like residents by the Regional Clinical Nurse Specialist on 10/11/2023.	

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F 610	Continued From page 13 short on staff and they were held on to another room. TMA-A stated the incident did not strike her as concerning. TMA-A stated that before they were able to report the incident, the administrator and the director of nursing were already in R2's room investigating. TMA-A stated there was no staff re-education about the incident. During interview on 9/20/23 at 8:27 a.m., nursing assistant (NA)-A, indicated she was working with TMA-A during an incident (could not say exact date) helping R2 get up, when TMA-D entered the room and R2 was swearing and then TMA-D said something like "the person that talked to me like that does not talk anymore" in response to R2. NA-A stated after TMA-D left the room, they went to provide resident care in another room, and "within a couple of minutes" R2 called daughter to report what happened. NA-A stated that the daughter immediately called the adminsitrator and the DON, and they went to R2's room. NA-A stated the administrator and DON called them from doing residents' cares to talk about the incident, where they confirmed what they witnessed. NA-A stated there was no staff re-education after the incident related to abuse reporting and reporting timeframes. NA-A stated, "It happens all the time there, there is no follow-through on everything and very inconsistent administration." During interview on 9/19/23 at 3:02 p.m., the DON stated the staff members who witnessed the incident had to be called for interview after R2's daughter called to report the incident. The DON stated they substantiated R2's allegation, however, members were not re-educated about abuse and what to do when witnessing an incident of abuse.	F 610	2. To correct the deficiency and to ensure the problem does not recur all staff were educated on the Vulnerable Adult Policy on 10/13/2023 by the Director of Nursing. The Executive Director and/or designee will audit all alleged violations for thorough investigation and interventions 3x/week for 1 month, 2x/week for 1 month, weekly for 1 month, and then randomly to ensure continued compliance. 3. As part of Green Lea Senior Living□s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community□s QA Process.	

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F 610	Continued From page 14 The policy titled, Vulnerable Adult, updated on 10/19/22, provides that facility supports "Zero Tolerance" for resident abuse, neglect, mistreatment, and/or misappropriation of resident property. The policy provides all employees will be required to attend training through orientation and annual meetings on issues related to abuse prevention/intervention. The policy indicates that training includes abuse and misappropriation of resident's property, and notification of covered individuals of their reporting obligations to report reasonable suspicion of a crime to the SSA (State Survey Agency), and local law enforcement. The policy also indicates facility will provide periodic drills across all levels of staff to ensure covered individuals understand reporting requirements.	F 610		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/19/23 to 9/20/23, a complaint survey was conducted at your facility by surveyor from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed.	2 000		

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2 000	Continued From page 1 H55365485C (MN00096714) H55365723C (MN00095780) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		