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	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Lea Senior Living	115 North Lyndale, Rr 2 Box 49 Mabel, MN 55954

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 50764 Based on observation, interview, and record review, the facility failed to ensure ambulation program was provided to maintain mobility to reduce the risk for falls as ordered by physical therapy for 1 of 1 resident (R2) who had a history of falls. Findings include: R2's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R2 had intact cognition, no rejection of care, was independent with toileting hygiene, required partial assistance with showering, personal hygiene, was independent with bed mobility, utilized a walker and wheelchair, and walking was listed as not applicable. Diagnoses included heart failure, arthritis, and kidney failure. R2's care plan revised 8/9/24, indicated R2 had limited physical mobility with fall risk r/t disease process, functional loss, and history of falls on 2/18/24, 3/14/24, 4/2/24, and 7/24. Interventions per therapy recommendation dated 3/8/24, included patient ambulation 3x/day with use of 2WW (two wheeled walker) and CGA (contact guard assistance) with wheelchair brought behind, distance as tolerated. A facility document titled PT Discharge Summary dated 6/7/24, indicated R2 was set up on an appropriate carryover program for ROM/strengthening and ambulation to include ambulation with staff. The document further stated R2's prognosis to maintain CLOF (current level of functioning) was good if there was consistent staff follow-through. In review of R2's record between 7/14/24 and 8/14/24, there was no documentation that identified R2's ambulation program had been completed or was offered. During interview on 8/14/2024 at 8:26 a.m., R2 stated that facility staff did not ask him to walk. R2 further stated that he would walk with staff if they had time, but they were too busy. R2 stated he did not remember a recent time staff walked with him in the hallway. During observation on 8/14/2024 at 10:28 a.m., R2 was observed walking independently in the hallway with a walker. R2 stated that he would walk by himself if staff were too busy. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/14/2024 at 11:01 a.m., nursing assistant (NA)-A stated walks are almost impossible to get done. NA-A further stated R2 does not get walked three times per day and R2 does not refuse, walks just don't get done. During interview on 8/14/2024 at 1:07 p.m., NA-B stated she did not know who was supposed to be walked or how she would find that information and further stated she did not walk residents. NA-B stated she did not have time to complete walks but would have time if they had more staff. During interview on 8/14/2024 at 1:20 p.m., licensed practical nurse (LPN)-A stated that walking was not done due to the staff being busy. LPN-A further stated that residents at the facility required a lot of care and that caused the staff to be too busy to complete walking programs. LPN-A confirmed there was no documentation of walking or refusals and no way of tracking if walking was being completed. During interview on 8/14/2024 at 12:13 p.m., physical therapist (PT) stated therapy gave walking recommendations to nursing when R2 completed therapy. PT stated nursing was supposed to take the program over and continue the walking. PT further stated a form titled Rehab Communication was given to nurses, nursing assistants, and the director of nursing with directions for R2's walking program that included ambulation with staff. PT expected nursing to complete that program. PT did not think R2 had declined in function and stated she had observed R2 walking independently at baseline functional ability, although R2 required staff assistance for walking. During interview on 8/14/2024 at 1:40 p.m., director of nursing (DON) stated therapy gave recommendations for walking programs and staff were expected to follow those recommendations. DON further stated if R2 was supposed to be assisted with walking, she expected staff would complete the walking as ordered. The facility Walking Program policy was requested but not received.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to ensure the Facility Assessment identified the facility's staffing needs based on the care needs of the resident population. This had the potential to affect all 32 residents who resided in the facility. Findings include: Refer to F688. The Facility assessment dated [DATE], included a Purpose Statement, The purpose of this assessment is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. It further identified the assessment would address staffing needs and noted This facility assessment will be used to: Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care; Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population; consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population. It identified the administrator as the person responsible for ensuring the completion of the facility assessment. The Facility assessment dated [DATE], included a section titled Information About Nurse Staffing Plans used to determine staffing needs based on the facility assessment of the resident population to ensure a sufficient number of staff to care for residents' needs. The Overall Staffing Needs table was incomplete and lacked details regarding how many staff members in different nursing roles were needed in total or on average. The Staffing Needs as per Resident Unit table was blank and failed to identify the ratio of staff to residents or hours per resident day of direct care needed for nursing positions on different facility units. The Staffing Needs as per Shift table was incomplete and failed to identify the ratio of staff to residents or hours per resident day of direct care needed for nursing positions for each shift. The Facility Assessment did not identify the direct care resident population staffing requirements for the overall facility, the various units upon which residents resided, or the various employee shifts. In an interview on 8/14/24 at 1:32 p.m., the administrator stated the Overall Staffing Needs table noted the number of registered nurses and nursing assistants the facility needed to hire to be fully staffed with facility-employed nursing staff. She stated the Staffing Needs as per Shift table similarly identified the number of nursing staff the facility needed to hire in different roles on different shifts. The administrator noted the Facility Assessment was most recently re-done at the end of July with her boss and noted it was confusing and she had mis-understood the Information About Nurse Staffing Plans. The administrator was unable to provide evidence of where the Facility Assessment identified the facility's staffing needs for nursing to provide sufficient staff to care for residents' needs.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49338 Based on interview and document review, the facility failed to maintain a complete, accurately documented, and readily accessible medical record in accordance with accepted professional standards and practices for 1 of 1 resident (R1) reviewed for medical record accuracy. Findings include: R1's provider orders included a treatment order dated 5/8/24, directing staff to complete a Body Audit assessment weekly one time a day every Friday. R1's treatment administration record (TAR) included the Body Audit assessment order scheduled on Fridays. R1's TAR dated 7/1/24 to 7/31/24, included charting of the Body Audit assessment as completed on 7/5/24, 7/12/24, 7/19/24, and 7/26/24. R1's TAR dated 8/1/24 to 8/31/24, included charting of the Body Audit assessment as completed on 8/2/24 and not completed on 8/9/24. Review of R1's electronic health record (EHR), identified Body Audit assessments dated 7/5/24, and 7/12/24. R1's EHR lacked records of the Body Audit assessments charted as completed on 7/19/24, 7/26/24, and 8/2/24. In an interview on 8/13/24 at 12:25 p.m., licensed practical nurse (LPN)-A stated skin assessments are done by nurses weekly on bath days and charted in the Body Audit assessment in the EHR. LPN-A noted the Body Audit will show up on a resident's TAR on the day and shift it is due to be completed. In an interview on 8/14/24 at 2:26 p.m., the director of nursing (DON) stated skin assessments are completed weekly on bath/shower days and a Body Audit assessment should be completed in the EHR. The DON noted completion of the weekly Body Audit assessment was standard policy and procedure. The DON confirmed the most recent Body Audit in R1's EHR was dated 7/12/24 and noted this was not in line with her expectation as they should be completed weekly at a minimum. The DON confirmed R1's TAR included completion of the weekly Body Audit assessment on Fridays and confirmed the Body Audit was charted as completed on 7/19/24, 7/26/24, and 8/2/24. The DON stated her medical record isn't accurate because they are charting things that we don't see. The DON stated she did not see a record of the Body Audit assessments from 7/19/24, 7/26/24, or 8/2/24 and they should be in here. Facility policy titled On-line Documentation dated January 2024, included guidance for uploading documents into electronic medical records. It did not address professional standards and practices for the maintenance of complete and accurate medical records.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 50764 Based on observation, interview, and record review, the facility failed to ensure proper infection control procedures were followed for 2 of 2 residents (R3 and R4) when staff failed to follow enhanced barrier precautions (EBP) while providing cares and treatment. Findings include: R3's face sheet printed 8/14/24, indicated diagnoses of pressure ulcer of right buttock stage 4 and chronic kidney disease. R3's quarterly Minimum Data Set (MDS) assessment indicated R3 had severe cognitive impairment, lower extremity impairment on both sides, use of a wheelchair, dependent on staff for toileting hygiene, bathing, lower body dressing, and substantial assistance for personal hygiene, and indwelling bladder catheter. R3's care plan revised 3/25/23, indicated a self-care performance deficit r/t (related to) right buttock pressure ulcer and two staff assistance for transfers with use of a standing mechanical lift. R3's care plan revised 6/19/24, also indicated the presence of an indwelling foley catheter with a goal of no signs or symptoms of urinary infection, risk of infection due to indwelling catheter and wound with an intervention of enhanced barrier precautions (EBP). R3's physician wound treatment order dated 7/31/24, directed twice daily dressing changes. During an observation on 8/14/24 at 10:21 a.m., A sign on R3's bathroom door informed staff of the need for gown and gloves with high-contact care activities, including wound treatments. Licensed practical nurse (LPN)-A completed R3's wound treatment without wearing a gown. LPN-A confirmed she had not worn a gown during the dressing change and should have. LPN-A reported she did not recall if she had education on EBP, and noted she did not always remember to use EBP while performing cares to residents where EBP was required. During an observation on 8/14/24 at 12:54 p.m., nursing assistant (NA)-A assisted R3 with transfer and catheter care without wearing a gown. NA-A stated she forgot to use EBP, they were too busy and hot to put on a gown all the time. NA-A further stated she was unsure if she had training on EBP. During an interview on 8/14/24 at 1:07 p.m., NA-B stated they did not usually wear EBP and she was unsure if she had been trained on EBP. NA-B explained EBP supplies and signs used to be in the hallway outside R3's door but had recently been moved into the bathrooms of the resident rooms, which made it harder for her to remember. R4's face sheet printed 8/14/24, indicated R4 had diagnoses of dementia, chronic pain syndrome, weakness, and retention of urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's entry MDS assessment dated [DATE], indicated intact cognition, dependence on staff for toileting hygiene, bathing, dressing, and transferring, need for intermittent catheterization, frequent bowel and bladder incontinence, and an unstageable pressure ulcer of the buttocks. R4's care plan revised 6/6/24, indicated a self-care performance deficit r/t Parkinsonism and cognitive disorder with interventions of two staff assistance for commode use and two staff assistance with standing mechanical lift for transfers. The care plan further indicated an impairment to skin integrity r/t unstageable left and right buttocks moisture associated skin damage (MASD). R4's wound orders dated 8/13/24, directed staff to apply a combination of creams, dampened gauze, and an ABD (larger absorbent dressing) to the wound twice per day. During an observation on 8/14/24 at 12:35 p.m., LPN-A completed R4's wound treatment without wearing a gown. NA-A and NA-B were also present and assisted R4 with toileting and pericare without wearing a gown. NA-A and There was no signage or supply cart observed in R4's room for EBP. During an interview on 8/14/24 at 12:57 p.m., R4 stated he had never seen staff use a gown when assisting him with using the commode or when taking care of his wound. During an interview on 8/14/24 at 1:45 p.m., director of infection prevention and quality assurance stated EBP should be used for catheters, chronic wounds, and anything in the guidance. A review of facility education material titled Relias Official Transcript and printed 8/14/24 indicated LPN-A, NA-A, and NA-B had all completed a training in 2024 titled Infection Control: Enhanced Barrier Precautions. A facility document section titled Enhanced Barrier Precautions updated 5/6/24 indicated an order for EBP would be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers) and/or indwelling medical devices (e.g., urinary catheters) even if the resident is not known to be infected or colonized with a MDRO. An additional section labeled Implementation of Enhanced Barrier Precautions indicated EBP should be used for high-contact resident care activities to include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care (urinary catheters), and wound care (any skin opening requiring a dressing- excluding shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing.