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	09/26/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure safe transfers for 1 of 1 resident (R1) while using a mechanical lift and did not follow the correct procedure for applying the straps of the sling to the lift. As a result, the sling became unhooked from the mechanical lift, R1 fell to the floor, and sustained a hematoma (collection of blood outside a blood vessel) to the back of her head, and fractures to the left 3rd, 4th, and 6th ribs which resulted in an immediate jeopardy (IJ).The IJ began on 9/15/25 when facility staff failed to follow manufacturer directions for connecting a sling to a mechanical lift and R1 fell from the lift. The Administrator, nurse consultant, and director of nursing (DON) were notified of the past non-compliance (PNC) IJ on 9/26/25 at 11:35 a.m. The facility immediately implemented and began corrective action on 9/15/25, and the deficient practice was corrected on 9/17/25, prior to the start of the survey and was therefore issued as a PNC IJ.Findings include:R1's face sheet dated 9/26/25, identified diagnoses of spondylosis of the lumbosacral and cervical region (stiffening of the spine), pain in right shoulder, and muscle weakness.R1's annual Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact and had no behaviors. R1 required maximum assistance to transfer between surfaces.R1's care plan revised on 9/16/25, identified R1 required two staff assistance to transfer with the mechanical lift. Staff refer to the mechanical lift sling size list posted at the nurses station and NA charting room for sling size.The facility Nursing Home Incident Report (NHIR) dated 9/19/25, identified on 9/15/25 staff used two slings and did not follow facility protocol. Staff were transferring R1 into a shower chair for a shower. Sling noted to be too small and instead of removing sling under resident the staff placed another sling under resident and hooked up both slings on the mechanical lift.R1's progress note dated 9/15/25 at 4:06 p.m., identified licensed practical nurse (LPN)-A received a call over the radio system to come to R1's room STAT (immediately). LPN-A entered the room and observed the bath chair with brakes locked, in the middle of the room. The mechanical lift was in the highest position, with two straps of the sling connected to the lift, and two straps dangling. Brakes on the mechanical lift were locked. R1 was observed below the lift with the left side of her head on the floor directly by the left front wheel of the bath chair, left side of body on the floor, left foot on the platform of the mechanical lift, with right leg crossed over the top of her left leg, left shoulder under body with left arm across chest to right shoulder, right arm was holding a nursing assistants (NA) hand. R1 stated she hit her head and LPN-A felt a quarter-sized lump on the back of her head. LPN-A took R1's vital signs. To prevent further injuries, LPN-A called for an ambulance to assist with lifting R1 and sent R1 to the emergency room for evaluation.R1's progress note dated 9/15/25 at 10:44 p.m., identified R1 returned to facility with a diagnosis of head injury. R1 complained of back pain and agreed to sleep in bed for pain management and ease of ability to make observations for further injuries. R1 was given hydromorphone (opioid given for moderate to severe pain) at 10:30 p.m. with a dose of Tylenol for pain rated 7/10.R1's emergency room After Visit Summary (AVS) dated 9/15/25, identified R1 was seen for a head injury. A Computed Tomography (CT) was done on R1's head and an x-ray of the left femur was completed.R1's progress note dated 9/16/25 at 3:06 a.m., identified R1 continued to have mild pain to left rib area and sensitivity to hematoma on the left back of head.R1's progress note dated 9/17/25 at 10:15 a.m., identified R1 was seen by her physician for follow-up from the fall on 9/15/25.R1's physician visit note dated 9/17/25, identified R1 unable to participate in rotator cuff muscle testing due to pain and limited range of motion. R1 was not able to lift her left elbow or shoulder off the bed due to pain. R1 reported significant pain all along her left side. R1 stated everything felt stiff. R1 was lying in bed for exam, which was unlike her as she typically detests her bed and prefers to sleep in her recliner.R1's progress note dated 9/21/25 at 3:30 a.m., identified R1 had 8/10 left rib pain. R1 was only able to move/shift very gently and limited in her bed. R1 refused to roll or be transferred from bed due to the pain as it intensified with upper body movement. R1 also had left upper arm pain with any left arm movement and kept the left arm resting across her chest. R1 stated the pain became worse on 9/20/25 in the afternoon. emergency room evaluation was offered and R1 refused at this time. Reviewed emergency department after visit summary from 9/15/25, and identified no chest x-ray had been completed. R1 questioned if she had broken ribs. Area under left breast very tender to touch. Unable to determine obvious asymmetry, bulge, or deformity. Skin is pink where R1's hand was resting, otherwise no bleeding or bruising visible. Mild to moderate discomfort with deep breaths, ok with regular breathing. Not in respiratory distress and oxygen saturations were between 91-96% on room air, with respirations 17-20 breaths per minute.R1's progress