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	10/17/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 fallsFindings 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 [DATE], 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 [DATE], 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 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 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 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.

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	245536	A. Building B. Wing	10/17/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] (R1's admission date), identified R1was 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 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.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

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	245536	A. Building B. Wing	10/17/2025

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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)

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	245536	A. Building B. Wing	10/17/2025

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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 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 . 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 [DATE], 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 [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 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 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

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	10/17/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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	245536	A. Building B. Wing	10/17/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE], 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 [DATE], 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

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	245536	A. Building B. Wing	10/17/2025

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] identified the following:-NA-B's nurse aide certificate expired on [DATE].-NA-H's nurse aide certificate expired on [DATE].-NA-I's nurse aide certificate expired on [DATE].-NA-L's nurse aide certificate expired on [DATE].The facility's employee records were reviewed on [DATE] and identified NA-B, NA-H, NA-I, and NA-L were scheduled and completed shifts from [DATE] thought [DATE] with an expired nurse aide certificate.During an interview on [DATE] 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 [DATE]. 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 licenses. During an interview on [DATE] 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, orb. 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.

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	10/17/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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	10/17/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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.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.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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 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 [DATE], 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 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.