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	04/08/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and documentation, the facility failed to comprehensively assess and monitor a wound for 1 of 3 residents (R3) reviewed for wound care.Findings include:R3's diagnoses list dated 4/7/26 included orthopedic aftercare following surgical amputation, acquired absence of right leg below the knee, and other complications of amputation stump.R3's significant change Minimum Data Set (MDS) dated [DATE] identified R3 did not have cognitive impairment. R3's received surgical wound care.R3's care plan dated 3/24/26 indicated a risk for impaired skin integrity related to surgical intervention right below the knee amputation (BKA), decreased mobility and need for assistance with personal cares. Interventions included but were not limited to dressing change every other day initiated on 3/31/26 and evaluate skin integrity. The care plan also included R3 has peripheral vascular disease (PVD) related to diabetes mellitus type 2 and hypertensive heart disease with chronic kidney disease. Interventions included but were not limited to BKA related to PVD: right leg: inspect incisions daily, drain in place, cover with gauze and abdominal pad followed by stump protector initiated on 3/17/26.R3's outside wound care provider note dated 3/23/26 indicated R3's wound drain was removed on 3/23/26. R3's wound care order dated 3/23/26 instructed: dressing change every other day to right stump wound. Irrigate with normal saline (water) and dry. Pack wound with Mesalt ribbon (narrow strip of gauze dressing) in wound 5.5 centimeters going almost straight down. Cover with Mepilex border dressing (a foam wound dressing).R3's progress note dated 4/5/26 at 4:20 p.m. indicated wound care was provided as ordered. Moderate amount of sanguineous and purulent drainage. Tunneling approximately 7-7.5cm. Peri wound saturated with brown, yellow, and green drainage. No odor. Surrounding tissue pink. Leg dry and flaky, lotion applied. Resident denied pain or discomfort.In review of R3's wound documentation records between 3/1/26 and 4/5/26 revealed although there were wound mentions with descriptions the assessments/monitoring there was no indication a comprehensive assessment was completed that included measurements in order to determine improvement or deterioration. During an observation on 4/6/2026 at 4:18 p.m. R3 was sitting in a wheelchair with his right leg elevated in a padded brace with Velcro straps. During an interview, R3 stated he had a wound to his right stump that had been giving him trouble. He was going to an outside wound care provider who assessed the wound and took measurements. R3 could not recall the last time a facility nurse measured the wound.During an interview on 4/6/2026 at 4:32 p.m., licensed practical nurse (LPN)-a stated there was an order on the resident's TAR to measure wounds once a week. The measurements would be written down in the wound book. Every resident wound had a page in the book. A registered nurse needed to complete the weekly wound measurements and assessments.During an observation on 4/7/2026 at 9:43 a.m., R3's wound page was observed in the wound care binder. Weekly dates were entered along with dressing change order. The page did not include measurements nor characteristics of the wound. During an interview, registered nurse (RN)-A stated Friday was wound measurement day. Measurements were documented in the weekly wound care binder. Description of the wound characteristics wound be documented in a wound note. Monitoring of the wound was done with every dressing change. RN-A confirmed the weekly wound care binder did not contain measurements of R3's wound. RN-A stated she was uncertain whether she (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would measure R3's wound on Fridays because he was seen by an outside wound care provider every other week who measured the wound. RN-A stated she would look for a wound note in R3's chart or the wound care provider notes to determine if the wound was improving or deteriorating.During an interview on 4/8/2026 9:46 a.m., medical doctor (MD) stated nurses should be documenting what a wound looks like with every dressing change and measured at least weekly. MD expected to be notified if a wound was deteriorating. MD would ask the nurse about R3's wound because she could not rely on documentation in the chart for description of the wounds. MD did not know about the book with weekly wound measurements. Measurements and a description of the wound were especially important for R3 because his wound had deteriorated several times so the wound needed close monitoring.During an interview on 4/8/2026 at 10:48 a.m. nurse consultant (NC) stated the director of nursing (DON) would add an order to the resident's TAR for wound measurement on Fridays when an RN was working. NC stated R3's wound note on 4/5/26 was a good description of the wound but did not contain measurements. NC confirmed R3's did not contain weekly wound assessments in March 2026 or April 2026. A resident's wound should be measured weekly and a wound note written with the measurements and the nurse's assessment of the wound.The Wound Care policy dated 10/15/24 instructed the following information should be recorded in the resident's medical record:The type of wound care given.The date and time the wound care was given.The name and title of the individual performing the wound care.Any change in the resident's condition.All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound, weekly and as needed by wound nurse.Any problems or complaints made by the resident related to the procedure.If the resident refused the treatment and the reason(s) why.The signature and title of the person recording the data.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and document review, the facility failed to establish a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications stored in an emergency medication kit and failed to establish a system to account for medications brought from home and stored in the medication room. Findings include:During an observation on 4/7/2026 at 9:43 a.m., registered nurse (RN)-A was observed unlocking the medication room then unlocking a cabinet to access the emergency medication kits (e-kit). A small e-kit was labeled with a list of controlled medications including the number of stocked pills/bottles and was secured with a breakaway lock with numbers. A larger e-kit labeled with non-controlled medications was also secured with a breakaway lock with numbers. A binder was observed with an every shift listing of lock numbers and staff initials. During an interview, RN-A stated to remove a controlled medication the nurse would first check the resident's provider orders. If the order matched a medication in the e-kit, the nurse would break the lock on the e-kit, fill out the pharmacy usage form, remove the required medication, then place a new lock on the e-kit and record the new lock number in the binder. The usage form would be faxed to pharmacy then placed in a basket on the counter to be scanned into the resident's medical record. If the number of pills in the e-kit did not match the number indicated on the cover of the controlled e-kit, RN-A would contact the pharmacy to find out when the other pills had been removed. RN-A further stated if a resident admitted with home medications, the nurse would ask a family member to bring the medications home. If there were no family members available, the medications would be placed in the medication room until the resident discharged or the medications were destroyed with resident or family approval. RN-A did not know if there was a procedure to account for a resident's home non-controlled medications that were stored in the medication room.During an interview on 4/6/2026 at 4:32 p.m., licensed practical nurse (LPN)-A stated when a resident brings medications from home, the nurse would ask family to bring the medications home. If that was not possible, the medications would written down on a piece of paper, the medications placed into a plastic bag, list of medications attached to the bag, then the bag placed in the medication room.During an observation on 4/7/2026 at 11:35 a.m., trained medication assistant (TMA)-A opened an unlocked cabinet in the medication room and removed a gallon size bag filled with medication bottles. During an interview, TMA-A stated when a resident brought medications from home, the nurse would go through the bag to look for controlled medications then would give the bag to TMA-A to place in a medication room cabinet. TMA-A did not know what the procedure was to account for all the non-controlled medications a resident brought from home.During an interview on 4/7/2026 at 12:31 p.m., pharmacist (Ph) stated the facility should be accounting for all medications removed from the e-kit and complete an inventory every shift. E-kits were replaced at the pharmacy's discretion and might need to be accessed several times before replacement. During an interview on 4/7/2026 at 11:54 p.m. director of nursing (DON) stated a nurse should count the pills in the controlled e-kit before removing any medications and compare the number of pills in the e-kit with the number of stocked pills on the top of the e-kit. If the numbers are different, the nurse would look at the pharmacy usage sheet that was placed in the e-kit from a previous medication removal. If there were no completed sheets in the e-kit, the nurse should call the pharmacy for information about any pills that had been removed since the last e-kit replacement. During an interview on 4/8/2026 at 9:59 a.m., the nurse consultant (NC) stated when a resident brings medications from home, a nurse would ask family to take the medications out of the facility. If there is no one to take the medications, a nurse should document all the medications including the number of pills in a nurse's note in the resident's electronic medical record.The Controlled Substance Storage policy dated 4/1/2019 instructed at each shift change or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented.The Medications Brought (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the Facility by a Resident or Responsible Party policy dated 4/1/19 instructed a licensed nurse to receive the medication delivered to the facility and documented delivery of the medication on the appropriate form/chart.