

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2025
NAME OF PROVIDER OR SUPPLIER  Green Lea Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, observation, and record review, the facility failed to maintain respect and dignity for personal possessions for 1 of 2 residents (R28) reviewed who had his room searched and items removed without consent.</p> <p>Findings include:</p> <p>R28's quarterly Minimum Data Set (MDS) assessment dated [DATE] included no cognitive impairment. Furthermore, his mood assessment indicated he rarely socially isolated. R28 is independent with eating, oral hygiene, toileting, dressing, and repositioning. R28 required minimal cueing for showering/bathing.</p> <p>During interview on 6/03/25 at 11:20 a.m., R28 stated the previous administrator at the facility entered his room without his permission and searched his room, the administrator told him they were searching his room because they thought he was making moonshine with orange peels and water or mouthwash. They also confiscated his vape pens and won't give them back. R28 added the administrator came into his room without consent and removed multiple cups and dishes. R28 said he felt he can't trust anyone here because they come in whenever they want, and he feels socially isolated since they searched his room.</p> <p>During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R28 has not been treated respectfully. CNA-A stated the previous administration had entered and searched his room without his permission. CNA-A stated the administrator believed he was using his orange peels to make moonshine. CNA-A stated the administrator believed he also had illegal substances in his room. CNA-A confirmed law enforcement was not at the facility at any point. CNA-A stated the previous administrator had confiscated his vape pens.</p> <p>During interview on 6/5/25 at 4:06 p.m., director of nursing (DON) and administrator stated it was possible the previous administrator had entered and searched R28's room without his consent. The DON and administrator confirmed they were not at the facility at the time of the search. The administrator confirmed a note in the chart on 3/12/25 at 10:40 a.m., indicated the resident's room had been search without his consent. The administrator confirmed a note in the chart on 3/11/25 at 3:18 p.m., indicated facility staff had entered the resident's room without permission to remove facility property. The DON confirmed entering R28's room without permission could have a negative impact on his social well-being.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per facility policy titled Dignity and dated February 2021, facility staff must knock and request permission before entering a residents' room. Residents' private space and property are respected at all times; staff do not handle or move a resident's personal belongings without the resident's permission.</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to accommodate bathing/showering preferences for 1 of 1 resident (R1) reviewed for choices.</p> <p>Finding include:</p> <p>R1's admission Minimum Data Set (MDS) assessment dated [DATE] identified admission to the facility on 4/30/25, had intact cognition. R1 required substantial/maximal assistance from facility staff for shower/bathing.</p> <p>R1's care plan dated 5/7/25 contained only one item; R1 had a potential nutritional deficit related to Parkinson's, dementia, chronic pain and depression. The care plan lacked personal preference for showering/bathing preferences.</p> <p>During observation and interview on 6/3/25 at 11:05 a.m., R1 stated he preferred to have showers/baths on Monday, Wednesday, and Friday (M/W/F). R1 stated he rarely gets 3 showers/baths as he prefers; usually getting showers/baths 2 days per week; Tuesdays and Fridays.</p> <p>During interview on 6/4/25 at 10:34 a.m., R1 stated he told the facility when he was admitted he preferred showering/bathing on M/W/F; was assured by facility staff this request could be accommodated.</p> <p>R1's treatment administration record (TAR) dated May 2025 showed showering/bathing was completed on the following dates:</p> <ul style="list-style-type: none"> <li>-Tuesday, 5/6/25</li> <li>-Friday, 5/9/25</li> <li>-Tuesday, 5/13/25</li> <li>-Friday, 5/16/25</li> <li>-Tuesday, 5/20/25</li> <li>-Saturday, 5/24/25</li> <li>-Friday, 5/30/25</li> <li>-Tuesday, 6/3/25</li> </ul> <p>During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R1's showering/bathing schedule was Tuesdays and Fridays. CNA-A stated the assistant director of nursing (ADON) or the director of nursing (DON) completed the resident preferences on admission; however, with the change in leadership she is unsure who completed resident preferences for R1.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/05/2025 at 11:47 a.m., ADON stated the (DON) does the admission care plan. ADON stated a baseline care plan is done with admission assessments to include resident name, code status, primary diagnosis, continence, skin, activities of daily living (adl's); the baseline care plan should contain resident preferences for showering/bathing schedule. ADON confirmed R1 did not have a comprehensive care plan.</p> <p>Per facility policy titled Care Plans-Baseline dated March 2022; a baseline (temporary) Care Plan to meet the resident's immediate health and safety needs is developed for each resident during the first shift of admission. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment.</p>

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<p>F 0568</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Based on interview and document review, the facility failed to ensure resident's trust account statements were provided on, at least, a quarterly basis. The lack of provided statements had the potential to affect all residents with trust accounts at the care center.</p> <p>During the recertification survey from 6/2/25 to 6/5/25, a facility complaint regarding access to funds was investigated. An incidental finding during this investigation revealed the facility was not sending quarterly statements to residents or resident representatives.</p> <p>During interview on 6/3/25 at 24:45 p.m., business office manager (BOM) stated the facility does not send out quarterly statements.</p> <p>During interview on 6/4/25 at 8:57 a.m., administrator confirmed the facility does not send out quarterly statements.</p> <p>An undated facility policy titled Accounting and Records of Resident funds; individual accounting records are made available to the resident through quarterly statements and upon request.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to develop a person-centered care plan for 2 of 2 residents (R19, R1) reviewed for care planning.</p> <p>Findings include:</p> <p>R19</p> <p>R19's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R19 was cognitively intact with no behaviors. R19 had limited range of motion to one lower extremity, supervision with eating and oral cares, partial moderate assistance for toileting hygiene and bathing and lower body dressing, and supervision with bed mobility. The MDS indicated R19 was frequently incontinent of urine and bowel and had multiple medical conditions including: atrial fibrillation (abnormal rhythm of the heart), heart failure, hypertension (high blood pressure), peripheral vascular disease (impaired blood flow to extremities), renal insufficiency (impaired kidney function), diabetes, anxiety, and schizophrenia (mental health diagnosis), R19's admission MDS also indicated R19 had a history of falls prior to admission. The MDS indicated R19 received insulin injections (medication to treat elevated blood sugar), antipsychotic (medication to treat mental health disorders), antidepressant (medication to treat depression and other mental health disorders), anticoagulant (medication used to prevent blood clots), and diuretic (medication used to treat fluid accumulation). Care areas triggered included communication, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and psychotropic drug use. The care areas triggered were documented addressed on care plan.</p> <p>R19's care plans included dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognition and needing reminders of scheduled activities dated 5/19/25, Resident to be discharged to alternative living facility/community dated 5/23/25, advanced directive-[R19] has chosen the code status of full code dated 5/23/25, potential nutrition problem dated 5/7/25, and potential impairment to skin integrity . dated 5/12/25.</p> <p>R19's record lacked a person-centered comprehensive care plan.</p> <p>R19's temporary care plan (care plan given to nursing assistants) included admitting diagnoses, diet, assist for cares, continence, oral care, skin issues, and therapy orders.</p> <p>R19's physician orders included amlodipine, losartan, spironolactone, and metoprolol for hypertension, Eliquis for atrial fibrillation, furosemide for congestive heart failure, olanzapine for schizophrenia, and aspart insulin injections for diabetes.</p> <p>During an interview on 6/5/25 at 10:12 a.m., LPN-A stated R19 admitted to the facility for rehab services, kept to himself, and had no behaviors. LPN-A stated the director of nursing (DON), assistant director of nursing (ADON), or MDS coordinator enter in care plans at admission.</p> <p>R1</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's admission Minimum Data Set (MDS) assessment dated [DATE] identified admission to the facility on 4/30/25, R1 was cognitively intact with no behaviors. The MDS indicated R1 had a functional impairment of both the left upper and left lower limbs. R1's MDS also indicated R1 needed partial to moderate assistance with eating and oral hygiene. Further, R1 was dependent on facility staff for toileting, dressing, and mobility. R1 was frequently incontinent of bowel and had an indwelling catheter to drain his bladder. The care areas triggered were communication, activities of daily living, indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain management. The care areas triggered were documented addressed on care plan.</p> <p>R1's admission diagnosis included, Parkinson's disease (movement disorder of the nervous system that worsens over time), dementia (general decline in cognitive ability that affect a person's ability to perform everyday activities), high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm).</p> <p>R1's care plan dated 5/7/25 contained only one item; R1 had a potential nutritional deficit related to Parkinson's, dementia, chronic pain and depression. The care plan lacked areas triggered on the MDS assessment.</p> <p>At the time of the re-certification survey from 6/2/25 to 6/5/25, R1's comprehensive care plan had not been completed.</p> <p>During interview on 6/05/25 at 11:41 a.m., certified nursing assistant (CNA)-A stated R1's showering/bathing schedule was Tuesdays and Fridays. CNA-A stated the assistant director of nursing (ADON) or the director of nursing (DON) completed the resident preferences on admission; however, with the change in leadership she is unsure who completed resident preferences for R1.</p> <p>During interview on 6/5/25 at 11:47 a.m., the ADON stated admission assessments and reconciliation of provider orders is performed by her or the DON. The comprehensive care plans are entered by the DON. A baseline care plan is implemented immediately upon admission that consists of a resident's name, code status, admitting diagnoses, continence, skin, and instructions for ADL's. A copy of the baseline care plan is located at the nursing assistant station. The comprehensive care plan is developed over a period after admission. The ADON confirmed R19 and R1 did not have a comprehensive care plan.</p> <p>A facility policy titled Care Plans-Baseline dated March 2022, staff conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission).</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interview and document review, the facility failed to ensure the services of a registered nurse (RN) onsite for 8 consecutive hours/7 days a week. This had the potential to affect all residents who resided at the facility.</p> <p>Findings include:</p> <p>The payroll based journal (PBJ) staffing report for quarter 2 of 2025 (January 1-March 31) indicated no RN hours reported for the following days : 1/02 (TH), 1/03 (FR), 1/04 (SA), 1/05 (SU), 1/09 (TH), 1/18 (SA), 1/19 (SU), 2/02 (SU), 2/16 (SU), 3/1 (SA), 3/02 (SU), 3/15 (SA), 3/16 (SU), 3/29 (SA), 3/30 (SU).</p> <p>Review of facility payroll and staffing schedules indicated 4 hours of RN coverage on 1/4/2025 and no RN coverage for 1/05, 1/18, 1/19, 2/02, 2/16, 3/01, 3/02, 3/15, 3/16, 3/29, and 3/30.</p> <p>During interview on 6/3/25 at approximately 3 p.m., the regional nurse consultant confirmed there was no RN coverage for the indicated dates and confirmed it is an expectation to have an RN in the building 8 consecutive hours a day/ 7 days a week.</p> <p>During an interview on 6/5/25 at 12:17 p.m., the assistant director of nursing (ADON) stated the staffing coordinator is responsible for nursing schedules. The ADON stated there has been no issue with services not being provided due to not having an RN on duty for 8 consecutive hours.</p> <p>During an interview on 6/5/25 at 3:15 p.m., the staffing coordinator indicated there are two staff RNs who work at the facility. One RN works full time on the overnight shift, the other recently started and works evenings. The staffing coordinator confirmed struggling to have RN coverage every other weekend.</p> <p>A policy titled Staffing, sufficient and competent Nursing dated April 2025 line 3 indicated A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the residents and based on the facility assessment.</p>