Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2025

Administrator
AVERA GRANITE FALLS CARE CENTER

250 JORDAN DRIVE
GRANITE FALLS, MN 56241

RE: CCN:245243
Cycle Start Date: September 10, 2025

Dear Administrator:

On September 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the

Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 11, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 11, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145

St. Paul, MN 55101

Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245243**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CENTER	**250 JORDAN DRIVE , GRANITE FALLS, Minnesota, 56241**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	F0880 SS=F Infection Prevention and Control- Employee Illness' logs Upon review of employee illness surveillance log, it found that illness tracking was not met per regulatory compliance. Education was initiated in Daily Huddles and Email was sent out on 10/01/2025 to all staff regarding Employee Illness protocol. Employee must communicate with a Licensed Staff to complete Pink Illness sheet. Employees are instructed to call employee Health at 605-322-7859. Pink Slips will be submitted to Administrative Assistant to track absences, then routed to IP and then will be audited by DON for compliance. General guidelines from Employee Health, you must be symptom free x 24 hours before returning to work. If it is a communicable disease, you will be guided upon return to work by Employee Health. Employee Health logs into the Employee EMR and the email is sent out to the Leader. If there are trends identified by employee health the will reach out to the local employee health worker. Employee Health is now tracking trends for the System along with the IP. Tracking will be reviewed in correlation with Resident illness by IP. Audits will be put on Score Card and and reviewed in QAPI monthly.	11/26/2025

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 reverse for further 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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F0880 SS = F	Continued from page 1 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employees would be able to return to work after an illness, dependent upon their symptoms and resolution of illness for 3 of 3 staff nursing assistant (NA)-A, NA-B, and infection preventionist (IP)-A. This had the potential to affect all 48 residents who resided at the facility. Findings include: Review of the employee illness form and log identified the following information was to be obtained:NamePosition Manager Date/time symptoms startedDates/Shifts worked 48 hours within symptoms starting or date of test if asymptomaticLast day workedDate of covid-19 test Did you have close contact	F0880		

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F0880 SS = F	Continued from page 2 with patient being within 6' for greater than 15 minutes cumulative time?Were you ever within 6' of other employees without a mask? Review of the facility staff illness forms and surveillance logs from August of 2025 through September 8 of 2025 identified the following. On:8/9/25, NA-B had symptoms of cough, congestion, and body aches. Covid test was negative. The log did not identify the last day worked, when the symptoms had resolved, or when the staff returned to work.8/31/25, NA-A had symptoms of feeling unwell. The log did not identify what symptoms the staff was experiencing, the last shift they had worked, when the symptoms had resolved, or when the staff had returned to work.9/8/25, Infection preventionist had respiratory symptoms, was afebrile, a covid test was completed on 9/8 and 9/9, and results were negative. The log did not identify the last shift worked, when the symptoms resolved, or when the staff returned to work. Interview on 9/10/25 at 11:21 a.m., with the infection preventionist identified the facility uses a form that should be completed when a staff calls in an absence due to illness. Staff do not always enter all the information that is required. Since "Covid has calmed down" and processes have changed, some of the employee illness requirements of documentation have "fallen through the cracks". She was hired as the IP in April of 2025, and was still in training. She was enrolled in classes to become certified, but she has not started yet. If she had questions, she could ask registered nurse (RN)-B who is a certified infection preventionist. Interview on 9/10/25 at 1:49 a.m., with RN-B identified She was not the IP at the facility but is certified from previous employment. She is not providing oversite to the new IP. She was delegated to assist the IP if needed. She thought the staff illness logs were being completed and identified if she was to be providing oversite to the IP, nobody had told her. Interview on 9/10/25 at 1:49 p.m., with the director of nursing (DON) identified she should have made it clearer what her expectations were of RN-B regarding providing oversite. RN-B had mentioned in the past to her, that she was unable to find any staff illness logs and had concerns that it was not getting done. The DON believed they had a lack of communication and identified they would be starting a performance improvement project (PIP) immediately to fix this	F0880		

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F0880 SS = F	Continued from page 3 concern. Review of the facilities current Infection Prevention and Control Job Description identified essential job functions included being proficient in surveillance using National Healthcare Safety Network surveillance definitions for healthcare associated infections. Reviews, investigates, and analyzes surveillance data. Works collaboratively with Employee Health and individual departments to educate staff, monitor compliance, and recommend improvements.	F0880		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate training and oversight of the infection control (IC) program by management by performing current, daily cumulative infection control surveillance activities, maintain documentation of incidents, findings, and any corrective actions required, and ensure the IC program continued while the newly hired IP completed training. Findings include:	F0882	F0882 SS=F ON 9/10/2025 it was identified during survey that the newly hired IP/Quality Nurse did not have oversight while she was in training and obtaining her IP Certification. Email sent to RN B (IP Certified) to provide oversight to current IP Nurse while she obtains her certification. Duties to include assessment competency and accuracy in her IP responsibilities. New IP to acknowledge adequate education to successfully manage the responsibilities of her IP role independently. Infection and Preventionist and Policy established by DON to identify and maintain the Care Centers Infection Preventionist, designed to help prevent the development and transmission of disease and infection. IP Illness Logs and IP surveillance will be discussed in QAPI monthly to ensure regulatory compliance. IP obtained her certification on 10/10/2025 and is confident and works with Regional IP to develop process related to her job role.	11/26/2025

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F0882 SS = F	Continued from page 4 Review of the employee illness form identified the following information was to be obtained:NamePosition Manager Date/time symptoms startedDates/Shifts worked 48 hours within symptoms starting or date of test if asymptomaticLast day workedDate of covid-19 test Did you have close contact with patient being within 6' for greater than 15 minutes cumulative time?Were you ever within 6' of other employees without a mask? Review of the facility staff illness forms and surveillance logs from August of 2025 through September 8 of 2025 identified the following. On:8/9/25, NA-B had symptoms of cough, congestion, and body aches. Covid test was negative. The log did not identify the last day worked, when the symptoms had resolved, or when the staff returned to work.8/31/25, NA-A had symptoms of feeling unwell. The log did not identify what symptoms the staff was experiencing, the last shift they had worked, when the symptoms had resolved, or when the staff had returned to work.9/8/25, Infection preventionist had respiratory symptoms, was afebrile, a covid test was completed on 9/8 and 9/9, and results were negative. The log did not identify the last shift worked, when the symptoms resolved, or when the staff returned to work. Interview on 9/10/25 at 11:21 a.m., with the infection preventionist identified the facility uses a form that should be completed when a staff calls in an absence due to illness. Staff do not always enter all the information that is required. Since "Covid has calmed down" and processes have changed, some of the employee illness requirements of documentation have "fallen through the cracks". She was hired as the IP in April of 2025, and was still in training. She was enrolled in classes to become certified, but she has not started yet. If she had questions, she could ask registered nurse (RN)-B who is a certified infection preventionist. Interview on 9/10/25 at 1:49 a.m., with RN-B identified She was not the IP at the facility but is certified from previous employment. She is not providing oversite to the new IP. She was delegated to assist the IP if needed. She thought the staff illness logs were being completed and identified if she was to be providing oversite to the IP, nobody had told her. Interview on 9/10/25 at 1:49 p.m., with the director of nursing (DON) identified she should have made it	F0882		

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F0882 SS = F	Continued from page 5 clearer what her expectations were of RN-B regarding providing oversite. RN-B had mentioned in the past to her, that she was unable to find any staff illness logs and had concerns that it was not getting done. The DON believed they had a lack of communication and identified they would be starting a performance improvement project (PIP) immediately to fix this concern. Review of the facilities Infection Prevention and Control Job Description identified essential job functions included being proficient in surveillance using National Healthcare Safety Network surveillance definitions for healthcare associated infections. Reviews, investigates, and analyzes surveillance data. Works collaboratively with Employee Health and individual departments to educate staff, monitor compliance, and recommend improvements.	F0882		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F0755	Audits completed by DON after receiving Weekly Medication Audits from Support Nurses. Trend noted in expired insulin and eye drops that required to be replaced. Initiated on 11/26/2025 Shift to Shift Cart Audits to be reviewed by Support Nurse daily and returned to DON to monitor for trending and regulatory compliance, 1. Email will be sent out 11/26/2025 regarding new shift/shift audits to ensure residents are not receiving expired medications. Will continue will weekly Med room/Cart Audits and Medication Fridge Audits. 2. If shift cart audits are not completed, the DON will monitor Licensed Staff that are not in compliance. 3. Audits will be placed on Score Card and discussed in Monthly QAPI Meetings for compliance.	11/26/2025

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F0755 SS = D	Continued from page 6 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to establish an effective system of monitoring for expired medication and ensure expired medication was not used for 1 of 1 resident (R5). Findings include: R5's 7/3/25, annual Minimum Data Set (MDS) assessment identified R5's cognition was moderately impaired, she required set up assistance for cares, and walked independently with a wheeled walker. R5 had diagnosis of atrial fibrillation (abnormal heart rhythm), heart failure, hypertension, peripheral vascular disease, and constipation. Observation and interview on 9/10/25 at 8:46 a.m., with registered nurse (RN)-A of the A-side medication room identified RN-A opened the door to the refrigerator inside the medication room for review and took out a plastic cup that was about 1/4 full of what looked like chocolate ensure. The cup was not covered or labeled with a date or a resident name. Further review of the refrigerator identified a box of bisacodyl suppositories with an expiration date of 7/31/25. The label on the box identified 12 suppositories were dispensed and only 7 remained in the box. RN-A stated R5 does not use or has not used them "in a long time". R5's 9/10/25, medication orders identified an order for Dulcolax (bisacodyl) 10 milligrams (mg) rectal daily as needed (PRN) for constipation. Give on 4th day without bowel movement (BM). The last administration date was 8/30/25. R5's August 2025 and September 2025, Medication Administration record identified R5 was administered Dulcolax Bisacodyl Suppository 10 mg rectally on 8/28/25 and 8/30/25 after the expiration date. Interview on 9/10/25 at 11:00 a.m., with R5 who reported she had a suppository about 2 weeks ago and	F0755		

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F0755 SS = D	Continued from page 7 one not too long ago. She stated I really have not had much trouble with constipation but one of my other pills have caused some constipation. She stated she would rather not have to use a suppository but sometimes you have to do what you have to do. Interview on 9/10/25 at 11:13 a.m., with the director of nursing (DON) who identified the facility does audits every month however, she had not received any audits from RN-A for the A side of the building which is where R5 resides. She shared an audit completed by RN-B for the B side of the facility that was last completed on 7/16/25, which identified RN-B removed 2 bottles of expired eye drops. The DON stated she would expect staff to be checking expiration date prior to administering any medications. Review of July 2024, Medication Orders and Administration policy identified medications would be administered only with clear, complete orders. The medication must specify the name of medication, strength of medication, dose to be administered, the frequency of administration, the route of administration, duration, and diagnosis or indication for use. The policy had instructions for new orders, verbal orders, standing orders, discontinued orders, medication labels, reporting of adverse reactions, medication errors, and medication administration. The policy had no mention of monitoring for checking expired medication prior to administration.	F0755		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has	F0883	FO883 SS=D Upon Document review during survey 1 out 5 records reviewed R24 was not offered the pneumococcal vaccination as recommended by the CDC It is the policy of this facility to follow the recommendations of the CDC for residents vaccinations unless contraindicated, resident has already had the vaccination. Resident immunizations status will be reviewed on admission and annually thereafter to ensure pneumococcal vaccinations are up to date. Upon admission the Infection Preventionist or Support Nurse will access MIIC to review the residents current vaccination status. The CDC PneumoRecs Vax Adviser tool will be utilized to determine what vaccinations are recommended for the resident.	11/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CENTER	**250 JORDAN DRIVE , GRANITE FALLS, Minnesota, 56241**

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F0883 SS = D	Continued from page 8 the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 sampled residents (R24) was offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include:	F0883	Continued from page 8 The Pharmacy also sends out recommendations that the resident should have according to their records. The recommendation will be communicated to the RN Support Nurse and resident provider to regarding current recommendations, vaccinations will be offered and if resident or POA declines, declination will be documented and in the EMAR. Audits completed on New admissions and Annually, vaccination audits will be recorded and reviewed in the monthly Quality Meeting.	

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F0883 SS = D	Continued from page 9 Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV 21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV 21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV 21) at any age and a PPSV23 at or after the age of 65 years old. Review of R24's immunization record identified she had received a PPSV-23 on 11/19/03, and a PCV-13 on 10/7/15. Interview on 9/10/25 at 1:49 p.m., with the director of nursing identified that staff checked the Minnesota Immunization Information Connection (MIIC) online and if there are no recommendations listed, they do not offer any. She noted their process was not up to date as the recommended immunizations per CDC were not always listed on that website. She agreed R24 should have been offered the PCV20 or PCV21 upon admission. A policy was requested but was not provided by the end of the survey.	F0883		
E0000	Initial Comments On 9/08/25 through 9/10/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		11/25/2025
F0000	INITIAL COMMENTS On 9/08/25 through 9/10/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements	F0000		11/25/2025

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F0000	Continued from page 10 for Long Term Care Facilities. The following complaints were reviewed: H52433480C (2604961) and H52433481C (2592727). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		

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F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	F0880 SS=F Infection Prevention and Control- Employee Illness' logs Upon review of employee illness surveillance log, it found that illness tracking was not met per regulatory compliance. Education was initiated in Daily Huddles and Email was sent out on 10/01/2025 to all staff regarding Employee Illness protocol. Employee must communicate with a Licensed Staff to complete Pink Illness sheet. Employees are instructed to call employee Health at 605-322-7859. Pink Slips will be submitted to Administrative Assistant to track absences, then routed to IP and then will be audited by DON for compliance. General guidelines from Employee Health, you must be symptom free x 24 hours before returning to work. If it is a communicable disease, you will be guided upon return to work by Employee Health. Employee Health logs into the Employee EMR and the email is sent out to the Leader. If there are trends identified by employee health the will reach out to the local employee health worker. Employee Health is now tracking trends for the System along with the IP. Tracking will be reviewed in correlation with Resident illness by IP. Audits will be put on Score Card and and reviewed in QAPI monthly.	11/26/2025

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 reverse for further 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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NAME OF PROVIDER OR SUPPLIER: AVERA GRANITE FALLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 250 JORDAN DRIVE , GRANITE FALLS, Minnesota, 56241		

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F0880 SS = F	Continued from page 1 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employees would be able to return to work after an illness, dependent upon their symptoms and resolution of illness for 3 of 3 staff nursing assistant (NA)-A, NA-B, and infection preventionist (IP)-A. This had the potential to affect all 48 residents who resided at the facility. Findings include: Review of the employee illness form and log identified the following information was to be obtained:NamePosition Manager Date/time symptoms startedDates/Shifts worked 48 hours within symptoms starting or date of test if asymptomaticLast day workedDate of covid-19 test Did you have close contact	F0880		

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F0880 SS = F	Continued from page 2 with patient being within 6' for greater than 15 minutes cumulative time?Were you ever within 6' of other employees without a mask? Review of the facility staff illness forms and surveillance logs from August of 2025 through September 8 of 2025 identified the following. On:8/9/25, NA-B had symptoms of cough, congestion, and body aches. Covid test was negative. The log did not identify the last day worked, when the symptoms had resolved, or when the staff returned to work.8/31/25, NA-A had symptoms of feeling unwell. The log did not identify what symptoms the staff was experiencing, the last shift they had worked, when the symptoms had resolved, or when the staff had returned to work.9/8/25, Infection preventionist had respiratory symptoms, was afebrile, a covid test was completed on 9/8 and 9/9, and results were negative. The log did not identify the last shift worked, when the symptoms resolved, or when the staff returned to work. Interview on 9/10/25 at 11:21 a.m., with the infection preventionist identified the facility uses a form that should be completed when a staff calls in an absence due to illness. Staff do not always enter all the information that is required. Since "Covid has calmed down" and processes have changed, some of the employee illness requirements of documentation have "fallen through the cracks". She was hired as the IP in April of 2025, and was still in training. She was enrolled in classes to become certified, but she has not started yet. If she had questions, she could ask registered nurse (RN)-B who is a certified infection preventionist. Interview on 9/10/25 at 1:49 a.m., with RN-B identified She was not the IP at the facility but is certified from previous employment. She is not providing oversite to the new IP. She was delegated to assist the IP if needed. She thought the staff illness logs were being completed and identified if she was to be providing oversite to the IP, nobody had told her. Interview on 9/10/25 at 1:49 p.m., with the director of nursing (DON) identified she should have made it clearer what her expectations were of RN-B regarding providing oversite. RN-B had mentioned in the past to her, that she was unable to find any staff illness logs and had concerns that it was not getting done. The DON believed they had a lack of communication and identified they would be starting a performance improvement project (PIP) immediately to fix this	F0880		

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F0880 SS = F	Continued from page 3 concern. Review of the facilities current Infection Prevention and Control Job Description identified essential job functions included being proficient in surveillance using National Healthcare Safety Network surveillance definitions for healthcare associated infections. Reviews, investigates, and analyzes surveillance data. Works collaboratively with Employee Health and individual departments to educate staff, monitor compliance, and recommend improvements.	F0880		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate training and oversight of the infection control (IC) program by management by performing current, daily cumulative infection control surveillance activities, maintain documentation of incidents, findings, and any corrective actions required, and ensure the IC program continued while the newly hired IP completed training. Findings include:	F0882	F0882 SS=F ON 9/10/2025 it was identified during survey that the newly hired IP/Quality Nurse did not have oversight while she was in training and obtaining her IP Certification. Email sent to RN B (IP Certified) to provide oversight to current IP Nurse while she obtains her certification. Duties to include assessment competency and accuracy in her IP responsibilities. New IP to acknowledge adequate education to successfully manage the responsibilities of her IP role independently. Infection and Preventionist and Policy established by DON to identify and maintain the Care Centers Infection Preventionist, designed to help prevent the development and transmission of disease and infection. IP Illness Logs and IP surveillance will be discussed in QAPI monthly to ensure regulatory compliance. IP obtained her certification on 10/10/2025 and is confident and works with Regional IP to develop process related to her job role.	11/26/2025

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F0882 SS = F	Continued from page 4 Review of the employee illness form identified the following information was to be obtained:NamePosition Manager Date/time symptoms startedDates/Shifts worked 48 hours within symptoms starting or date of test if asymptomaticLast day workedDate of covid-19 test Did you have close contact with patient being within 6' for greater than 15 minutes cumulative time?Were you ever within 6' of other employees without a mask? Review of the facility staff illness forms and surveillance logs from August of 2025 through September 8 of 2025 identified the following. On:8/9/25, NA-B had symptoms of cough, congestion, and body aches. Covid test was negative. The log did not identify the last day worked, when the symptoms had resolved, or when the staff returned to work.8/31/25, NA-A had symptoms of feeling unwell. The log did not identify what symptoms the staff was experiencing, the last shift they had worked, when the symptoms had resolved, or when the staff had returned to work.9/8/25, Infection preventionist had respiratory symptoms, was afebrile, a covid test was completed on 9/8 and 9/9, and results were negative. The log did not identify the last shift worked, when the symptoms resolved, or when the staff returned to work. Interview on 9/10/25 at 11:21 a.m., with the infection preventionist identified the facility uses a form that should be completed when a staff calls in an absence due to illness. Staff do not always enter all the information that is required. Since “Covid has calmed down” and processes have changed, some of the employee illness requirements of documentation have “fallen through the cracks”. She was hired as the IP in April of 2025, and was still in training. She was enrolled in classes to become certified, but she has not started yet. If she had questions, she could ask registered nurse (RN)-B who is a certified infection preventionist. Interview on 9/10/25 at 1:49 a.m., with RN-B identified She was not the IP at the facility but is certified from previous employment. She is not providing oversite to the new IP. She was delegated to assist the IP if needed. She thought the staff illness logs were being completed and identified if she was to be providing oversite to the IP, nobody had told her. Interview on 9/10/25 at 1:49 p.m., with the director of nursing (DON) identified she should have made it	F0882		

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F0882 SS = F	Continued from page 5 clearer what her expectations were of RN-B regarding providing oversite. RN-B had mentioned in the past to her, that she was unable to find any staff illness logs and had concerns that it was not getting done. The DON believed they had a lack of communication and identified they would be starting a performance improvement project (PIP) immediately to fix this concern. Review of the facilities Infection Prevention and Control Job Description identified essential job functions included being proficient in surveillance using National Healthcare Safety Network surveillance definitions for healthcare associated infections. Reviews, investigates, and analyzes surveillance data. Works collaboratively with Employee Health and individual departments to educate staff, monitor compliance, and recommend improvements.	F0882		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F0755	Audits completed by DON after receiving Weekly Medication Audits from Support Nurses. Trend noted in expired insulin and eye drops that required to be replaced. Initiated on 11/26/2025 Shift to Shift Cart Audits to be reviewed by Support Nurse daily and returned to DON to monitor for trending and regulatory compliance, 1. Email will be sent out 11/26/2025 regarding new shift/shift audits to ensure residents are not receiving expired medications. Will continue will weekly Med room/Cart Audits and Medication Fridge Audits. 2. If shift cart audits are not completed, the DON will monitor Licensed Staff that are not in compliance. 3. Audits will be placed on Score Card and discussed in Monthly QAPI Meetings for compliance.	11/26/2025

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F0755 SS = D	Continued from page 6 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to establish an effective system of monitoring for expired medication and ensure expired medication was not used for 1 of 1 resident (R5). Findings include: R5's 7/3/25, annual Minimum Data Set (MDS) assessment identified R5's cognition was moderately impaired, she required set up assistance for cares, and walked independently with a wheeled walker. R5 had diagnosis of atrial fibrillation (abnormal heart rhythm), heart failure, hypertension, peripheral vascular disease, and constipation. Observation and interview on 9/10/25 at 8:46 a.m., with registered nurse (RN)-A of the A-side medication room identified RN-A opened the door to the refrigerator inside the medication room for review and took out a plastic cup that was about 1/4 full of what looked like chocolate ensure. The cup was not covered or labeled with a date or a resident name. Further review of the refrigerator identified a box of bisacodyl suppositories with an expiration date of 7/31/25. The label on the box identified 12 suppositories were dispensed and only 7 remained in the box. RN-A stated R5 does not use or has not used them "in a long time". R5's 9/10/25, medication orders identified an order for Dulcolax (bisacodyl) 10 milligrams (mg) rectal daily as needed (PRN) for constipation. Give on 4th day without bowel movement (BM). The last administration date was 8/30/25. R5's August 2025 and September 2025, Medication Administration record identified R5 was administered Dulcolax Bisacodyl Suppository 10 mg rectally on 8/28/25 and 8/30/25 after the expiration date. Interview on 9/10/25 at 11:00 a.m., with R5 who reported she had a suppository about 2 weeks ago and	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CENTER	**250 JORDAN DRIVE , GRANITE FALLS, Minnesota, 56241**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 7 one not too long ago. She stated I really have not had much trouble with constipation but one of my other pills have caused some constipation. She stated she would rather not have to use a suppository but sometimes you have to do what you have to do. Interview on 9/10/25 at 11:13 a.m., with the director of nursing (DON) who identified the facility does audits every month however, she had not received any audits from RN-A for the A side of the building which is where R5 resides. She shared an audit completed by RN-B for the B side of the facility that was last completed on 7/16/25, which identified RN-B removed 2 bottles of expired eye drops. The DON stated she would expect staff to be checking expiration date prior to administering any medications. Review of July 2024, Medication Orders and Administration policy identified medications would be administered only with clear, complete orders. The medication must specify the name of medication, strength of medication, dose to be administered, the frequency of administration, the route of administration, duration, and diagnosis or indication for use. The policy had instructions for new orders, verbal orders, standing orders, discontinued orders, medication labels, reporting of adverse reactions, medication errors, and medication administration. The policy had no mention of monitoring for checking expired medication prior to administration.	F0755		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has	F0883	FO883 SS=D Upon Document review during survey 1 out 5 records reviewed R24 was not offered the pneumococcal vaccination as recommended by the CDC It is the policy of this facility to follow the recommendations of the CDC for residents vaccinations unless contraindicated, resident has already had the vaccination. Resident immunizations status will be reviewed on admission and annually thereafter to ensure pneumococcal vaccinations are up to date. Upon admission the Infection Preventionist or Support Nurse will access MIIC to review the residents current vaccination status. The CDC PneumoRecs Vax Adviser tool will be utilized to determine what vaccinations are recommended for the resident.	11/26/2025

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F0883 SS = D	Continued from page 8 the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 sampled residents (R24) was offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include:	F0883	Continued from page 8 The Pharmacy also sends out recommendations that the resident should have according to their records. The recommendation will be communicated to the RN Support Nurse and resident provider to regarding current recommendations, vaccinations will be offered and if resident or POA declines, declination will be documented and in the EMAR. Audits completed on New admissions and Annually, vaccination audits will be recorded and reviewed in the monthly Quality Meeting.	

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F0883 SS = D	Continued from page 9 Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV 21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV 21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV 21) at any age and a PPSV23 at or after the age of 65 years old. Review of R24's immunization record identified she had received a PPSV-23 on 11/19/03, and a PCV-13 on 10/7/15. Interview on 9/10/25 at 1:49 p.m., with the director of nursing identified that staff checked the Minnesota Immunization Information Connection (MIIC) online and if there are no recommendations listed, they do not offer any. She noted their process was not up to date as the recommended immunizations per CDC were not always listed on that website. She agreed R24 should have been offered the PCV20 or PCV21 upon admission. A policy was requested but was not provided by the end of the survey.	F0883		
E0000	Initial Comments On 9/08/25 through 9/10/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		11/25/2025
F0000	INITIAL COMMENTS On 9/08/25 through 9/10/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements	F0000		11/25/2025

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NAME OF PROVIDER OR SUPPLIER: AVERA GRANITE FALLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 250 JORDAN DRIVE , GRANITE FALLS, Minnesota, 56241		

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F0000	Continued from page 10 for Long Term Care Facilities. The following complaints were reviewed: H52433480C (2604961) and H52433481C (2592727). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 2, 2026

Administrator
AVERA GRANITE FALLS CARE CENTER
250 JORDAN DRIVE
GRANITE FALLS, MN 56241

RE: CCN: 245243
Cycle Start Date: September 10, 2025

Dear Administrator:

On December 3, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance.

The CMS location may determine to impose remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; **has been assessed a total civil money penalty of not less than $13,343**; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112