



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2025

Administrator
Gil-Mor Manor
96 THIRD STREET EAST
MORGAN, MN 56266

RE: CCN: 245594

Cycle Start Date: July 24, 2025

Dear Administrator:

On July 24, 2025, the Minnesota Department(s) 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; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



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August 6, 2025

Administrator
WABASSO RESTORATIVE CARE CENTER
660 MAPLE STREET
WABASSO, MN 56293

RE: CCN: 245400

Cycle Start Date: May 28, 2025

Dear Administrator:

On June 18, 2025, we notified you a remedy was imposed. On the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 16, 2025

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 3, 2025 has been discontinued as of July 16, 2025. (42 CFR 488.417 (b))

In our letter of June 18, 2025 in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 28, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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: 245594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2025	
NAME OF PROVIDER OR SUPPLIER Gil-Mor Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 96 THIRD STREET EAST , MORGAN, Minnesota, 56266			
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E0000	Initial Comments On 7/21/25 through 7/23/25, 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			08/16/2025	
F0000	INITIAL COMMENTS On 7/21/25 through 7/23/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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			08/16/2025	
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in		F0552	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal regulations of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with		09/01/2025	

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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F0552 SS = D	Continued from page 1 language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 5 residents (R1) had a Consent for Psychotropic Medication Use identifying the risks, benefits, and alternative treatments available. Findings include: R1's 5/30/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was intact, she had no signs of significant depression and displayed no behaviors. R1 had diagnosis of dementia and depression, she was administered an antidepressant on a routine basis and required assistance with activities of daily living (ADL)'s. R1's July 2025, Medication Administration Record identified she was administered citalopram 30 milligrams (MG) by mouth daily for major depressive disorder. Interview on 7/22/25 at 3:12 p.m., with registered nurse (RN)-A identified that the facility was to have the resident or resident representative sign a consent for psychotropic medication use when starting a medication. When an order was obtained for a psychotropic medication, the nurse should be reviewing the consent with the resident and/or representative of the risks and benefits and have the consent signed. She confirmed that R1's consent for use of a psychotropic medication for citalopram (an antidepressant), for the diagnosis of major depressive disorder had not been completed. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator identified they agreed with the above findings and would expect staff to ensure residents' who start a new psychotropic medication would be provided the risks, benefits, and alternative treatments available in writing. Review of the undated, Psychotropic Drug Policy and Procedure identified staff would provide the resident/resident representative with the indication, dose, side effects, adverse consequences and goal of treatment. They would obtain		F0552	Continued from page 1 the State Operations Manual. Gil-Mor Manor has and always will ensure that all residents will be fully informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he/she prefers. R1 consent has been completed. Whole house audit will be conducted to verify a signed consent for psychotropic medication has been completed. Consents will be reviewed quarterly at the resident's care conference. To ensure that this problem does not recur charge nurses will notify ADON when an antipsychotic medication is prescribed. ADON will verify that the resident has a signed consent for psychotropic medication use that includes the indication, dose, side effects, and adverse consequences. Staff Training on Psychotropic Medications consent requirement was reviewed with Nursing Staff on 8/5/2025. To ensure compliance, audits to be completed by ADON/designee to verify consents are signed weekly x4 weeks, monthly x3 months then randomly to ensure compliance. Audit results will be reported to the QAPI committee to determine ongoing compliance.			

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F0552 SS = D	Continued from page 2 the informed consent, and it would be added to the resident's medical record. The consents would be reviewed quarterly at the resident's care conference.	F0552		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F0582	Gil-Mor Manor has and always will ensure that it informs each resident before, or at the time of admission, and periodically during the resident's stay of services available in the facility and charges for those services, including those not covered by Medicare/Medicaid or by the facility's per diem rate using appropriate forms as required by state and federal law. All residents before, or at the time of admission, and periodically during their stay will be given all required forms to assure they are informed of their benefit changes which includes charges for those services not covered by Medicare/Medicaid or by the facility's per diem rate. Director of Nursing provided training and education on "Notice of Non-Medicare Coverage forms" with entire Nursing Staff on 8/5/2025. During the weekly Medicare meeting, the MDS Coordinator/designee, will review if any residents are changing coverage, in benefits, the appropriate form is used and will ensure communication is being given to the resident or responsible party no less than 48 hours (2 days) prior to last covered day. To ensure this, an audit will be conducted by the MDS Coordinator/designee on any changes of services, or benefits, weekly x4 weeks, then monthly x3 months with results being reported to the QAPI committee to determine ongoing compliance.	09/01/2025

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F0582 SS = D	Continued from page 3 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) CMS-10055 for 1 of 3 residents (R6) reviewed. Findings include: Review of R6's medical record identified she had received skilled Medicare covered services from 11/3/25 through 2/7/25. Review of R6's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) identified services had been discontinued by the facility prior to benefit days being exhausted. R6 had been notified on 2/6/25 that her coverage would end on 2/7/25. Interview on 7/22/25 at 2:13 p.m., with registered nurse (RN)-A identified she was responsible for providing the non-coverage notices to residents and had missed the deadline for providing the notice. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator agreed with the above findings and identified it was their expectation that staff would ensure the SNFABN notices would be provided no later than 2 days prior to the last covered day. Review of the 12/18/19 Issuing the NOMNC and SNFABN policy identified the SNFABN must be served to the beneficiary or person acting on the beneficiary's behalf no less than 48 hours (2 days) in advance. A progress note was to be recorded in the medical record when serving these notices.		F0582				
F0605 SS = D	Right to be Free from Chemical Restraints		F0605	Gil-Mor Manor has and always will ensure that all		09/01/2025	

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F0605 SS = D	Continued from page 4 CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F0605	Continued from page 4 residents will be free from any chemical restraints. It is Gil-Mor Manor's intent to ensure that all residents on psychotropic medication as needed will be assessed by provider every 14 days to determine if its appropriate for the PRN order to be extended beyond 14 days providing documented rationale indicating the duration for the PRN order. R4 PRN Ativan order was discontinued on 7/29/2025 by provider. R11 PRN clonazepam was decreased to once daily on 7/29/2025 by provider. Whole house audit will be conducted to verify all PRN psychotropic medications have been assessed. Staff Training on PRN Psychotropic Medications was reviewed with entire Nursing Staff on 8/5/2025. See Attachment E To ensure that this problem does not recur all PRN psychotropic medications will be logged into PCC with an end date of 14 days with notification to contact provider for reassessment to determine its appropriateness. RPh will review all PRN psychotropic medications monthly during chart review and make appropriate recommendations. All RPh recommendations will be provided to the Director of Nursing and Administrator for review monthly. To ensure compliance, audits to be completed by DON/designee to verify all PRN psychotropic medications are being reassessed every 14 days. Audits will be completed weekly x4 weeks, monthly x3 months then randomly to ensure compliance. Audit results will be reported to the QAPI committee to determine ongoing compliance.	

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F0605 SS = D	Continued from page 5 (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14		F0605				

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F0605 SS = D	Continued from page 6 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to have 2 of 6 residents (R4, R11) assessed by a physician for need to continue taking an as needed antianxiety medication. Findings include: R4 R4's 7/22/25, quarterly Minimum Data Set (MDS) assessment identified R4's cognition was intact and required minimal assistance with cares. R4 took an antianxiety and antidepressant medication. R4's 7/23/25, Medical Diagnosis list identified anxiety disorder, chronic obstructive pulmonary disease with exacerbations, pulmonary emphysema, major depressive disorder, alcohol dependence with alcohol induced anxiety disorder, and chest pain. R4's 7/23/25, Order Summary Report identified an order for Ativan 0.25 milligrams (MG) every 24 hours as needed (PRN) for anxiety started on 4/4/25. R4's 7/1/25, physician visit notes made no mention of a rationale for continued use of her Ativan PRN medication, or review of how often she was needing the medication and if it was effective and there was no documentation to support the physician had reviewed or renewed the Ativan PRN order since 4/4/25. R4's pharmacy reviews from April 29th, 2025, through July of 2025 all identified that a chart review had been completed with no concerns or recommendations. There was no indication that the pharmacist identified there was no end date or review date identified for the		F0605				

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F0605 SS = D	Continued from page 7 Ativan PRN order that had been initiated on 4/4/25. R11 R11's 6/20/25, quarterly MDS assessment identified R11's cognition was moderately impaired, and she required extensive assistance with cares. R11 took an antianxiety medication. R11's 7/23/25, Medical Diagnosis list identified a diagnosis of anxiety disorder. R11's 7/23/25, Order Summary Report identified an order for clonazepam (Klonopin) 0.25 mg every 12 hours PRN started on 11/7/24. R11's 5/20/25, physician visit notes made no mentioned of a rationale for continued use of her Klonopin PRN medication or review of how often she was needing the medication and if it was effective and there was no documentation to support the physician had reviewed or renewed the Klonopin PRN order from 11/7/24 to present. R11's pharmacy reviews from November 2024 through July of 2025 all identified that a chart review had been completed with no concerns or recommendations. There was no indication that the pharmacist identified there was no end date or review date identified for the Klonopin PRN order from 11/7/24 Interview on 7/22/25 at 3:12 p.m., with registered nurse (RN)-A identified R4 and R11's psychotropic PRN medications should have been re-assessed every 14 days unless the provider otherwise documented a rationale for use and an extended re-assessment time frame. RN-A felt the charge nurses knew psychotropic PRN medications need to be assessed every 14 days and was unsure why that had not occurred. She would be working on a new system to ensure that was occurring. Interview on 7/23/25 at 12:02 p.m., with consulting pharmacist (RPh) identified she reviewed as-needed medication while completing her monthly review. The RPh confirmed R4 had an order for Ativan PRN. R11 had started Klonopin PRN medication in November 2024. She typically checked psychotropic medications every 6 months and then yearly to see if there needed to be a		F0605				

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F0605 SS = D	Continued from page 8 dose change. The RPh confirmed neither R4 or R11 had a review that she could find since starting the psychotropic PRN medication. When a resident was on a psychotropic PRN medication, she would notify the facility a 14-day assessment needed to be completed. The RPH did not notify the provider of the need, but she did notify the facility, and they were expected to make sure it had been completed. Interview on 7/23/25 at 5:15 p.m., with director of nursing (DON) and administrator identified their expectation was all psychotropic PRN medications would be re-assessed by a physician every 14 days or have a documented rationale for continued use if an extended re-assessment timeframe was to occur. A policy on psychotropic as needed medications was requested but not provided by end of survey.	F0605		
F0755 SS = F	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;	F0755	Gil-Mor Manor intent has and always will be to ensure emergency medications are not expired. E-Kit was replaced on 7/24/2025 by pharmacy. E-Kit Policy reviewed, no changes. See Attachment A RPh will check E-Kit monthly during site visit to verify there are no expired medications. RPh will ensure all medications are clearly identified including expiration dates during monthly visit. Staff Training on E-Kit and expiration of medications was reviewed with entire Nursing Staff on 8/5/2025. See Attachment E To ensure compliance, audits to be completed by DON and designee to verify all medications in E-Kit are not expired. Audits will be completed randomly monthly to ensure compliance. Audit results will be reported to the QAPI committee to determine ongoing compliance.	09/01/2025

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F0755 SS = F	Continued from page 9 and §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 ensure emergency medications stored in 1 of 1 medication storage room were not expired. Findings include: Observation and interview on 7/23/25 at 12:33 p.m., with licensed practical nurse (LPN)-A of the medication room identified the emergency medication kit (E-kit) was observed sitting on the counter. On the top of the E-kit a sticker was observed that said exp (expiration) 6/27. LPN-A was not certain if that meant the medications in the E-kit expired on 6/27/25 or June of 2027. Observation of the medications inside the E-kit identified 2 Morphine filled syringes 4 milligrams/milliliter (mg/mL). The manufacturers expiration date printed on the syringe was June of 2025. In addition, there were several other medications that had printed medication expiration dates that were listed as expired and handwritten expiration dates that were listed as not expired. LPN-A agreed the medications listed were expired. She was not certain which date they were to use to determine if the medication was expired. Interview on 7/23/25 at 3:31 p.m., with the pharmacy contact person agreed the 2 morphine pre-filled syringes were expired. She identified the printed expiration dates on the other medications were for the prescription and the handwritten expiration dates were for the medications. She agreed it was unclear on the label but stated “the staff are aware”. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator identified they agreed with the above findings. They would have expected the pharmacy to remove the expired medications from the E-kit to avoid the potential administration of the outdated medications. In addition, they agreed that the expiration dates noted on the other medications in the Ekit were not clearly identified.		F0755				

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F0755 SS = F	Continued from page 10	F0755		
F0756 SS = D	A policy was requested but nothing was provided by the end of the survey period. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by:	F0756	Gil-Mor Manors intent is and always will be to ensure all residents drug regimen be reviewed at least once a month by a licensed pharmacist. R4 PRN Ativan order was discontinued on 7/29/2025 by provider. R11 PRN clonazepam was decreased to once daily on 7/29/2025 by provider. R28 Antibiotic was reviewed on 7/23/2025, discontinue order from provider was obtained. On 8/15/2025 Administrator reviewed with RPh regarding completing a monthly review of each resident's medication orders and medical record for potential irregularities and provide the facility with a written report identified irregularities, potential problems, or concerns. The completed monthly reports will be provided to Director of Nursing and Administrator. To ensure this problem does not recur the monthly pharmacy reports will be reviewed by the Infection Control Committee, with results being reported to the QAPI committee.	09/01/2025

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F0756 SS = D	Continued from page 11 Base on interview and document review, the consulting pharmacist (RPh) failed to identify irregularities for 3 of 8 sampled residents (R4, R11, and R28) reviewed. Findings include: R4 R4's 7/22/25, quarterly Minimum Data Set (MDS) assessment identified R4's cognition was intact, and she required minimal assistance with cares. R4 took an antianxiety and antidepressant medication. R4's 7/23/25, Medical Diagnosis list identified anxiety disorder, chronic obstructive pulmonary disease with exacerbations, pulmonary emphysema, major depressive disorder alcohol dependence with alcohol induced anxiety disorder, and chest pain. R4's 7/23/25, Order Summary Report identified the following order: Ativan 0.25 milligrams (MG) every 24 hours as needed (PRN) for anxiety started on 4/4/25 with no identified end date. R4's pharmacy reviews from April 29th, 2025, through June of 2025 all identified that a chart review had been completed with no concerns or recommendations. There was no indication the pharmacist identified or recommended a follow up with the provider as there was no end date or review date identified for the Ativan PRN order initiated on 4/4/25. R11 R11's 6/20/25, quarterly MDS assessment identified R11's cognition was moderately impaired, and she required extensive assistance with cares. R11 took an antianxiety medication. R11's 7/23/25, Medical Diagnosis list identified an anxiety disorder and hypertension. R11's 7/23/25, Order Summary Report identified an order for Clonazepam (Klonopin) 0.25 mg every 12 hours PRN started on 11/7/24 with no identified end date.		F0756				

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F0756 SS = D	Continued from page 12 R11's pharmacy reviews from November 2024 through June of 2025 all identified a chart review had been completed with no concerns or recommendations. There was no indication that the pharmacist identified or recommended a follow up with the provider as there was no end date or review date identified for the Klonopin PRN order that had been initiated on 11/7/24 R28 R28's 2/6/25, quarterly MDS assessment identified R28 cognition was intact, and he required extensive assistance with cares. R28 took an antibiotic, diuretic, and opioid medication. R28's 7/23/25, Order Summary Report identified the following order Minocycline HCl 100 mg every evening for infection and inflammatory reaction due to internal right knee prosthesis started on 1/13/23 with no identified end date. R28's pharmacy reviews from January 2025 through June 2025, all identified a chart review had been completed with no concerns or recommendations except for the month of March. In March there was a recommendation made for a dose reduction, if appropriate, for omeprazole 20 mg (a stomach acid reducer) as the resident had been on the since 2022. There was no indication the pharmacist identified or recommended a follow up with the provider as there was no end date or review for continued need for the Minocycline HCl order that was initiated on 1/13/23. Interview on 7/23/25 at 12:02 p.m., with the RPh identified she reviewed the as needed (PRN) psychotropic medication and antibiotics during her monthly review. If there was no identified end date or review date, she would make a recommendation to the facility to follow up on that. She confirmed R4 and R11 had not been reviewed for their PRN psychotropic medications and that R28 was on an antibiotic that had been ordered back in 2023, with no re-assessment she was aware of for continued need for use. When identified, she would make a recommendation to the facility to follow up on the concern. Interview on 7/23/25 at 5:15 p.m., with the director of nursing (DON) and the administrator identified they		F0756				

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F0756 SS = D	Continued from page 13 have a contract with the pharmacy. Their expectation was any identified irregularities, such as no end dates on a PRN psychotropic medication or an antibiotic that had been in place for an excessive amount of time, be brought to the facility for attention to review. They would expect any findings and recommendation to be documented for the facility to have documentation to ensure the recommendations were acted upon. Review of the 12/5/05, pharmaceutical consultant contract identified RPh would complete a monthly review of each resident's medication orders. The RPh was to review the residents' orders and medical record for potential irregularities and would provide the facility with a written report of identified irregularities, potential problems, or concerns.		F0756				
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility		F0757	Gil-Mor Manors intent is and always will be to ensure residents are free from unnecessary drugs. R28 Antibiotic was reviewed on 7/23/2025, discontinue order from provider was obtained. On 8/15/2025 Administrator reviewed with RPh regarding completing a monthly review of each resident's medication orders and medical record for potential irregularities and provide the facility with a written report identified irregularities, potential problems, or concerns. The completed monthly reports will be provided to Director of Nursing and Administrator. On 6/24/2025 all physicians were sent a letter informing them of the rules and regulations of the Antibiotic Stewardship Program letting them know that they will receive a 72-hour time out form to be completed by end of day and returned to Infection Preventionist with there recommendations on all antibiotics prescribed to our residents. See Attachment F To ensure this problem does not recur the Infection Preventionist will review the Order Listing Report in PCC every morning to determine if any residents were started on an antibiotic. IP will also verify those orders in the residents' EHR to determine the start and stop dates. All new antibiotic orders will be reviewed at morning stand up meeting with IDT (M-F). All 72-hour timeouts will be reviewed also.		09/01/2025	

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F0757 SS = D	Continued from page 14 failed to assess the need for continued use of an antibiotic for 1 of 5 sampled residents (R28) reviewed for antibiotic use. Findings include: R28's 2/6/25, quarterly MDS assessment identified R28 cognition was intact, and required extensive assistance with cares. R28 took an antibiotic, diuretic (fluid pill), and opioid (narcotic pain medication). R28's 7/23/25, Order Summary Report identified the following order Minocycline HCl 100 mg every evening for infection and inflammatory reaction due to internal right knee prosthesis started on 1/13/23 with no identified end date. Interview on 7/22/25 at 2:20 p.m., with the infection preventionist (IP) identified she was unaware and surprised that R28 was on an antibiotic that had been ordered back in 2023 and would be addressing that today. She was unaware the medication had been in place and did not believe anyone had assessed the need for continued use. The charge nurse usually gave all the antibiotics and somehow, R28's antibiotic was on the medication cart for the trained medication aide (TMA) to give. The charge nurse typically kept her updated on who was currently taking an antibiotic and since they were not giving it, she thought that was why it was missed for review. Interview on 7/23/25 at 12:02 p.m., with consulting pharmacist (RPh) identified R28 was on an antibiotic that had been ordered back in 2023 with no reassessment that she was aware of for continued need. R28 also had some skin issues, and the antibiotic was probably helpful for that. It was not uncommon to be on Minocycline HCl long term. If there was no end date on an antibiotic order, if noticed, she would bring that to the facilities attention for follow up to see if the medication was still needed. Interview on 7/23/25 at 5:15 p.m., with director of nursing (DON) identified R28's antibiotic order of Minocycline from 2023 should not have been "overlooked" that long. She would expect orders were being reviewed by the nurse, the RPh and the provider. There should not be any residents on an antibiotic for excessive duration without a provider assessing the continued		F0757	Continued from page 14 To ensure this problem does not recur the monthly pharmacy reports will be reviewed by the Infection Control Oversight Committee, with results being reported to the QAPI committee			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0757 SS = D	Continued from page 15 need. The facility "missed that, and we corrected that today and will be implementing a new process". Review of the undated, Antibiotic Stewardship policy identified the facility would provide efforts to optimize the use of antibiotic in order to maximize their benefits while minimizing resistance as well as adverse side effect. All antibiotic orders would include the diagnosis, medication, dose, route, and duration. Prophylactic antibiotic medication use in the facility would be limited based on the physician documentation of rationale, risks, and benefits for use.	F0757		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 emergency kit had been secured to avoid the potential for drug diversion. Findings include:	F0761	Gil-Mor Manors intent is and always will be to ensure that the E-Kit will be secured with a red numbered zip tie to avoid the potential for drug diversion. E-Kit was replaced on 7/24/2025 by pharmacy. RPh will check E-Kit monthly during site visit to verify the E-Kit is secured. Staff Training on E-Kit security with entire Nursing Staff on 8/5/2025. See Attachment E To ensure compliance, audits to be completed by DON and designee to verify the E-Kit is secured. Audits will be completed daily x7 days, then weekly x 12 weeks. Audit results will be reported to the QAPI committee to determine ongoing compliance.	09/01/2025

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F0761 SS = D	Continued from page 16 Observation, interview, and document review, on 7/23/25 at 12:33 p.m., with licensed practical nurse (LPN)-A of the medication room. The emergency medication kit (E-kit) was observed sitting on the counter. It had a black zip-tie secured on the closure. Over the black zip tie, was a red zip tie with a number (normal use secured latch) on it that was loosely placed. LPN-A pulled the tail of the red numbered zip tie, and it pulled from the E-Kit closure without being cut. LPN-A identified she was not aware why the red numbered zip tie was not securely placed on the E-kit, as it was facility policy the Ekit was to remain locked with the red zip tie and checked at each shift change to ensure the Ekit was appropriately locked and secured. The number on the zip tie matched the number documented in the Ekit count book. LPN-A noted this process was used to avoid the risk of potential drug diversion. A count of the E-kit was completed, and all medications were present. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator identified they agreed with the above findings and would expect staff to ensure the Ekit was properly secured at each shift change. If nursing should find the kit unsecure, the director of nursing and administrator should be notified immediately. Review of the 2/2/20, E-Kit Instructions policy provided by the facility identified the E-kit would be secured with a red numbered zip tie. The number would be recorded in the E-kit count book and would be checked at each shift change with 2 licensed nurses.	F0761		
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	F0880	Gil-Mor Manors intent is and always will be to 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 disease and infections. Surveillance for Infections Policy reviewed and updated and implemented. All staff will be educated on the new Surveillance for Infection Policy by their individual departments prior to date certain. See Attachment B & G New call-in procedure implemented to track employee infections. See Attachment D	09/01/2025

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F0880 SS = F	Continued from page 17 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: (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.		F0880	Continued from page 17 To ensure this problem does not recure all infections will be reviewed at morning stand up meeting with IDT (M-F). To ensure compliance, surveillance logs will be reviewed weekly at Leadership Meeting. Results will be reported to the QAPI committee to determine ongoing compliance.			

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F0880 SS = F	Continued from page 18 §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 have a thorough, ongoing infection control surveillance program that included resolution of symptoms and/or if any transmission-based precautions (TBP) had been implemented during 3 of 3 months reviewed (April, May, and June of 2025). The facility also failed to identify when employees would be able to return to work after having signs and symptoms of potential Norovirus for 8 of 8 staff (Cook-A, nursing aide (NA)-A, Cook-B, dietary (aide)-A, trained medication aide (TMA)-A, the infection preventionist (IP), NA-B, and TMA-B) reviewed for January of 2025. Findings include: Resident Surveillance Review of resident surveillance for April, May, and June of 2025, identified a form included the wing of the facility, resident name, and the onset date. The form also listed resident diagnoses of urinary tract infection, lower respiratory infection, upper respiratory infection, skin, blood, gastrointestinal infection, Foley catheter, Other, and fever. There was a place to document signs and symptoms, mental status change, identified organism, X-ray, treatment and dates, and the resolved date. The form had no place to document if any TBP had been implemented or removed or what the resolution date was or if there had been a need to alter treatment. Review of undated, Infection Surveillance policy identified prevention started with routine and ongoing surveillance to identify possible outbreaks and infections before they can spread to others. The facility would establish a system for collecting, analyzing and interpretation of the data to identify infections, risks and outbreaks.		F0880				

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F0880 SS = F	Continued from page 19 Interview on 7/22/25 at 2:20 p.m. with the IP identified she confirmed she had not been documenting a resolution date or had been identifying if a resident was placed on precaution or not on her surveillance. Staff surveillance Review of staff call in log for January, February, and March of 2025, identified a form the facility was using included an area to document, the report date, employee, vomiting, fever, diarrhea, jaundice, cough/sore throat/runny nose, infected skin lesions, fatigue/body aches, Comments or Other symptoms, date returned to work, and if they had notified the Minnesota Department of Health (MDH). Review of the month of January 2025, identified 8 staff with potential signs and symptoms of Norovirus: Dietary (cook)-A called in on 1/3/25, with vomiting and diarrhea and returned to work on 1/5/25, 2 days later.Nursing assistant (NA)-A called in on 1/7/25 with vomiting and returned to work on 1/8/25, 1 day later.Cook-B called in on 1/8/25 with vomiting and returned to work on 1/9/25, 1 day later.Dietary (aide)-A called in on 1/9/25 with vomiting and returned to work on 1/11/25, 2 days later.Trained medication aide (TMA)-A called in on 1/12/25 with vomiting and returned to work on 1/13/25, 1 day later.Infection preventionist called in on 1/16/25 with vomiting and diarrhea and returned to work on 1/17/25, 1 day later.NA-B called in on 1/22/25 with diarrhea and returned to work on 1/23/25, 1 day later.TMA-B called in on 1/24/25 with diarrhea and returned to work on 1/26/25, 2 days later. Interview on 7/22/25 at 2:20 p.m. with the IP identified staff had Norovirus back in January 2025, but no residents got sick. She agreed staff with signs and symptoms of Norovirus should have been out for a minimum of 48 hours after symptoms resolved according to the facility policy and the Norovirus reported to the MDH. When asked why she returned to work, she reported she did not “think” she had norovirus but that had not been confirmed by a physician. Continued interview on 7/23/25 at 10:30 a.m., with the IP identified no staff had confirmed norovirus, but she “suspected it” related to the signs and symptoms staff were calling in for. Staff were not allowed to return to work unless they had been symptom free for 24 hours		F0880				

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F0880 SS = F	Continued from page 20 without medication use. The IP was unaware the MDH required all staff with direct patient care duties, and duties for preparing and serving food were to be kept off work until 72 hours after all symptom resolution. Interview on 7/23/25 at 5:15 p.m., with the director of nursing identified her expectation was that staff followed the facilities policies and procedures for infection control surveillance and for staff illness and return to work. Review of the undated, Employee Illness policy identified examples of possible work restrictions for health care workers, that instructed the facility to contact their state department of health for clarification on work restriction. The policy identified employees with symptoms consistent with Norovirus infection, stay home for a minimum of 48 hours after symptom resolution. There was no indication the policy was reviewed for accuracy. Review of the 2024-2025, Minnesota Department of Health Norovirus information for Long-term care facilities, located at: https://www.health.state.mn.us/diseases/foodborne/outbr eak/facility/lcfnorotoolkit.pdf identified, common symptoms of Norovirus were diarrhea, vomiting, nausea, abdominal pain, low-grade fever, headache, and body aches. By Minnesota state law (Minn. Rules part 4605.7050), “any pattern of cases, suspected cases, or increased incidence of any illness beyond the expected number of cases in a given period” shall be reported immediately to MDH. This includes suspected outbreaks, increases in GI illnesses, or unusual disease activity at your facility. Facilities were to restrict healthcare workers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended.		F0880				
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that		F0881	Gil-Mor Manors intent is and always will be to complete a comprehensive assessment for continued use of an antibiotic. On 8/15/2025 Administrator reviewed with RPh regarding completing a monthly review of each resident’s medication orders and medical record for potential irregularities and provide the facility with a written report identified irregularities, potential problems, or concerns. The completed monthly reports will be provided to Director of Nursing and Administrator.		09/01/2025	

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F0881 SS = D	Continued from page 21 includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment for continued use of antibiotics for 2 of 3 (R1 and R17) sampled residents reviewed for antibiotic stewardship. Finding include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/c ore-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an "antibiotic time-out [ATO]". Review of the monthly resident surveillance for April 2025 through June 2025 identified columns to document location within the facility, resident name, onset date, type of illness, signs and symptoms, mental status changes, organism, treatment and dates, resolution, and comments. However, the log lacked evidence that the antibiotic had met criteria for continuation of use. Review of the April 2025, resident surveillance log identified R1 had been prescribed Azithromycin (Z-Pack) antibiotic medication 500 milligrams (mg) on day one, then 250 mg twice a day for 4 days. The onset of the infection occurred on 4/8/25 and lacked indication of an antibiotic assessment (time-out) 48-72 hours after starting to determine criteria met for continuation of use. Review of the June 2025, resident surveillance log identified R17 had been prescribed Doxycycline 100 mg twice a day for 10 days. The onset of the infection		F0881	Continued from page 21 On 6/24/2025 all physicians were sent a letter informing them of the rules and regulations of the Antibiotic Stewardship Program letting them know that they will receive a 72-hour time out form to be completed by end of day and returned to Infection Preventionist with their recommendations on all antibiotics prescribed to our residents. Antibiotic Stewardship Program was reviewed and updated. See Attachment C To ensure this problem does not recur the Infection Preventionist will review the Order Listing Report in PCC every morning to determine if any residents were started on an antibiotic. IP will also verify those orders in the residents' EHR to determine the start and stop dates. All new antibiotic orders will be reviewed at morning stand up meeting with IDT (M-F). All 72-hour timeouts will be reviewed also. To ensure compliance the monthly pharmacy reports will be reviewed by the Infection Control Committee, with results being reported to the QAPI committee			

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F0881 SS = D	Continued from page 22 occurred on 6/3/25 and lacked indication of an antibiotic time-out for continued use. R1's medical record had no mention that R1 had been assessed to be determined if the antibiotic was appropriate or effective. There was no indication of communication with the provider after starting the antibiotic. R17's medical record did identify in the progress notes assessment of R17's respiratory tract infection that included temperature, oxygens saturation level, antibiotic, and if signs or symptoms improved or not. However, the medical record lacked identification of communication with the medical provider regarding the assessment. Review of the monthly resident surveillance for April 2025 through June 2025 identified columns to document location within the facility, resident name, onset date, type of illness, signs and symptoms, mental status changes, organism, treatment and dates, resolution, and comments. However, the log lacked evidence that the antibiotic had met criteria for continuation of use. Review of the April 2025, resident surveillance log identified R1 had been prescribed Azithromycin (Z-Pack) antibiotic medication 500 milligrams (mg) on day one, then 250 mg twice a day for 4 days. The onset of the infection occurred on 4/8/25 and lacked indication of an antibiotic assessment (time-out) 48-72 hours after starting to determine criteria met for continuation of use. Interview on 7/23/25 at 2:18 p.m., with the administrator identified that the facility had concern with the providers not responding to the antibiotic time-outs, but the facility had not addressed the concern with the medical director or at the QAPI meetings. Interview on 7/23/25 at 5:15 p.m., with director of nursing (DON) identified her expectation was that antibiotic stewardship monitoring was being completed with each antibiotic that was started.		F0881				

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F0881 SS = D	Continued from page 23 Review of undated, Antibiotic Stewardship identified when a resident was suspected to have an infection the facility will communicate assessment findings to the practitioner using McGeer Criteria. If an antibiotic was prescribed the documentation would include diagnosis, medication, dose, route, and duration. The policy had no mention of an antibiotic assessment (time-out) 48-72 hours after starting to determine criteria met for continuation of use.	F0881		
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 control preventionist (IP) had provided oversight of the infection control program and the antibiotic stewardship program. Findings include: Review of monthly resident surveillance for April 2025 through June 2025, identified columns to document location within the facility, resident name, onset date, type of illness, signs and symptoms, mental status changes, organism, treatment and dates, resolution, and comments. The form lacked a column for antibiotic time-out and/or if precautions were	F0882	Gil-Mor Manors intent is and will always be to provide a designated infection control preventionist (IP) to provide oversight of the infection control program and the antibiotic stewardship program. The infection control and antibiotic stewardship program were reviewed updated. See Attachment B & C Gil-Mor Manor has three additional staff who hold Infection Preventionist Certification. These individuals will be part of the Infection Control Oversight Committee along with the Director of Nursing. To ensure compliance the committee will meet monthly to review surveillance logs and antibiotic stewardship program. Performance Improvement Project will be identified, results will be reported to the QAPI committee	09/01/2025

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F0882 SS = F	Continued from page 24 implemented. The form was not completed in full as the resolved date had not been identified and documented. Review of monthly staff surveillance for January 2025 through March 2025 identified columns to document call in date, employee, vomiting, fever, diarrhea, jaundice, cough/sore throat/runny nose, infected skin lesions/ fatigue/body aches, comments or other symptoms, date returned to work, notified health department. The surveillance identified 8 staff that returned to work prior to the recommended work restrictions for potential symptoms of norovirus. Interview on 7/23/25 at 10:30 a.m., with infection preventionist (IP) identified she was “unsure how” she provided oversight. She documented staff call-ins and symptoms that the staff reported to her. However, the charge nurse was supposed to be completing a call-in form but that had not been getting completed like it was supposed to. For resident surveillance, she reported she reviewed the 24-hour report upon arrival and if a resident had been started on an antibiotic she would go to the chart and review the documentation. For residents who were ill but not on an antibiotic, that information would be documented in the resident progress notes. She only documented residents on antibiotics on the monthly resident surveillance form. She revealed she had no documentation of any follow up for protocols not being followed. There “was not an effective process in place” to for providing oversight of the programs. Interview on 7/23/25 at 5:15 p.m., with the director of nursing (DON) identified her expectation was that the IP would be providing oversight of both the infection control program and the antibiotic stewardship program. The IP should be monitoring and ensuring the policies and protocols are being followed and if not, educate and implement a plan to correct why not being followed. The DON was unaware the IP was not performing her duties as required. Review of the 2020, Infection Prevention and Control Manual-Infection Surveillance Overview policy identified the intent of surveillance is to identify possible communicable diseases or infections before they can spread to other persons in the facility. In addition, Surveillance is crucial in the identification of possible clusters, changes in prevalent organisms, or increases in the rate of infection promptly. The		F0882				

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F0882 SS = F	Continued from page 25 results should be used to plan infection control activities, direct in-service education, and identify individual resident problems in need of intervention. 1.The Infection Preventionist (IP) was to collect and review data on an ongoing basis including:elevations in temperatures/presence of fever,purulent drainage,culture results or other diagnostic test results consistent with potential infections,change in X-ray results consistent with possible infection,increased falls,changes in mental status,changes in vital signs,signs and symptoms of infection based upon nationally accepted surveillance definitions (i.e. CDC/SHEA Position Statement: Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria or NHSN).2. The Infection Preventionist will ensure data collection to complete a comprehensive Monthly Infection Control Log for surveillance activities on:The infection sitePathogen (if known)Signs and SymptomsResident LocationSummary and Analysis of number of residents and/or staff with infectionsObservations of staff adherence to policies and proceduresIdentification of outcomes that are unusual or unexpected that could potentially lead to patterns, trends or outbreaks 3. The Infection Preventionist and the Infection Prevention and Control Committee were to utilize the information collected from both Process and Outcome Surveillance activities in order to calculate rates and analyze the data to identify opportunities for improved care and process and identify an action plan for follow up and corrective action and reporting. Findings are summarized and reported to the Infection Control (IC) oversight committee and departments that were observed. If indicated, a Performance Improvement Project will be identified and included as part of the QAPI process. A summary of results will be identified to the Quarterly OAA Committee. There was no indication the IP was being overseen by an IC committee.		F0882				

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/22/2025 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Gil-Mor Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR		K0000			08/16/2025	

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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Gil-Mor Manor is a one-story building without a basement and was determined to be built of Type II(111) construction. The original building was built in 1963, with an addition that was added in 1989. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The building is also divided into four separate smoke compartments to support a shelter-in-place strategy. The facility has a capacity of 35 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0324 SS = E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities		K0324	Gil-Mor Manors has and will always maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3		09/12/2025	

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K0324 SS = E	Continued from page 2 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. This deficient finding could have a patterned impact on the residents within the facility. Findings Include: On 07/22/2025 at 10:19 AM, it was revealed by observation that the residential stove located in the Activities Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0324	Continued from page 2 Electric timer for electric range in activity room has been ordered with estimate time of delivery is 9/10/2025. Estimate completion of 9/12/2025. See Attachment A To ensure compliance Maintenance Director will complete preventative maintenance inspection monthly.			
K0511 SS = F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric		K0511	Gil-Mor Manors has and always will comply with securing electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and maintain the Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2012 edition), National Electric Code, section 408.20.		08/16/2025	

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K0511 SS = F	Continued from page 3 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2011 edition), National Electric Code, section 408.20. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/22/2025, at 10:12 AM, it was revealed by observation that the electrical panel located by the public bathrooms was not secured. 2. On 07/22/2025, at 10:17 AM, it was revealed by observation that the electrical panel located in the Chapel was not secured. 3. On 07/22/2025, at 10:21 AM, it was revealed by observation that the electrical panel located at the Nurse's Station was not secured. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.		K0511	Continued from page 3 Locks have been placed on electrical panels located by public bathrooms, chapel and Nurse's station. See Attachment B To ensure compliance Maintenance Director will complete preventative maintenance inspections monthly			
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.		K0761	Gil-Mor Manors has and will always conduct inspections of fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. Summit Electric was at the facility on 8/11/2025, magnetic locks on emergency fire doors have been corrected. This was part of our fire panel upgrade. Fire Door inspections were completed in April 2025, and it was determined that all doors were compliant. See Attachment C		08/16/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Gil-Mor Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 96 THIRD STREET EAST , MORGAN, Minnesota, 56266			
(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	
K0761 SS = F	Continued from page 4 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:On 07/22/2025 between 9:00 AM and 11:15 AM, it was revealed by observation that the smoke barrier doors between the Living room and West Wing were wedged open with wooden wedges.On 07/22/2025 between 9:00 AM and 11:15 AM, it was revealed by observation that the smoke barrier doors between the Chapel and Dining room were wedged open with wooden wedges.On 07/22/2025 between 9:00 AM and 11:15 AM, it was revealed by observation that the smoke barrier doors between the Nurses Station and Dining room were wedged open with wooden wedges.On 07/22/2025 between 9:00 AM and 11:15 AM, it was revealed by observation that the doors at the 2 Hour wall between the Assisted Living and Nursing Home were wedged open with wooden wedgesAn interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0761	Continued from page 4 To ensure compliance Maintenance Director will monitor these monthly along with monthly fire drills			