DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 18, 2022

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: CCN: 245594
Cycle Start Date: May 27, 2022

Dear Administrator:

On June 14, 2022, we notified you a remedy was imposed. On July 7, 2022 the Minnesota Department(s) 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 6, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 29, 2022 be discontinued as of July 6, 2022. (42 CFR 488.417 (b))

In our letter of June 14, 2022, 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 27, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 18, 2022

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

Re: Reinspection Results
Event ID: M0OQ12

Dear Administrator:

On July 7, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 27, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted
June 14, 2022

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: CCN: 245594
Cycle Start Date: May 27, 2022

Dear Administrator:

On May 27, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 27, 2022, the situation of immediate jeopardy to potential health and safety cited at F888 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 29, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 29, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 29, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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 $11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 27, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 27, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
June 14, 2022

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

Re: State Nursing Home Licensing Orders
Event ID: M0OQ11

Dear Administrator:

The above facility was surveyed on May 23, 2022 through May 27, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 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
E 000	Initial Comments On 5/23/22 through 5/27/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 5/23/22 through 5/27/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5594023C MN78684, H5594023C MN78518, with a deficiency cited at F623. The survey resulted in an immediate jeopardy (IJ) at F888 which began on 5/7/22 when 1 of 7 residents (R2) became positive for COVID-19 after repeated staff COVID-19 outbreak infections since December 2021. The facility administrator and director of nursing (DON) were notified of the IJ on 5/26/22 at 3:58 p.m., which was identified as a L-WIDESPREAD. The IJ was removed on 5/27/22 at 2:45 p.m., but non-compliance remained at an F-WIDESPREAD, no actual harm with potential for more than minimal harm, that is	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 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
F 000	Continued From page 1 not immediate jeopardy. The above findings did not constitute Substandard Quality of Care; therefore NO extended survey was conducted. 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.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		6/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 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
F 623	Continued From page 2 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 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
F 623	Continued From page 3 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 623	All potential transfers or discharges will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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F 623	Continued From page 4 facility failed to timely notify 1 of 1 residents (R178) with written notification for a facility-initiated discharge. Findings include: Review of the 11/13/21 and 11/19/21, State Agency (SA) reports identified R178 had been discharged to the hospital on 10/29/21 for medical evaluation for osteomyelitis (bone infection). The regional hospital identified R178 was medically stable to return to the facility on 11/8/21. The facility was not agreeable to accept R178's return due to staffing shortages and their inability to meet R178's increased needs. The report alleged R178's needs had remained the same as R178 had been receiving wound care and lymphedema (edema) wraps prior to hospital admission. The report further identified R178 had been provided a bed hold from the facility but the facility had declined his return. R178's Admission Record identified admission date of 8/23/21, with diagnosis of lymphedema, hyperlipidemia, type 2 diabetes mellitus, morbid obesity, major depressive disorder, anxiety disorder, transient cerebral ischemic attack, macular degeneration, hypertension, atherosclerotic heart disease, pulmonary hypertension, atrial flutter, systolic heart failure, venous insufficiency chronic, cellulitis of bilateral lower limbs, chronic ulcers bilateral lower limbs, bilateral osteoarthritis of knee, idiopathic chronic gout, infection and inflammatory reaction due to internal right knee prosthesis sequel, and long term use of anticoagulants. R178's 8/30/21, admission Minimum Data Set (MDS) assessment identified R178's cognition	F 623	direst be reviewed and discussed during Gil-Mor Manor□s weekly Inter-departmental Team (IDT) Management Meeting. If the decision of the IDT Management Team is to issue a transfer or discharge notice, the social worker will locate placement that will meet the residents needs and the formal notification of transfer or discharge letter will be prepared by the Administrator or Designee. This notice will be hand delivered to the resident and a certified copy will be mailed to the resident representative(s). Additionally, there will be a progress note entered in PointClickCare listing all the required information, including the reasons for the transfer or discharge in the resident□s medical record. The transfer and/or discharge notification letter will provide notification to the resident and the resident□s representative(s) of the transfer or discharge that will include the following required contents in writing, in a language and manner they understand. The transfer/notice will include a. The reason for transfer or discharge. b. The effective date of the transfer or discharge. c. The location to which the resident is being transferred or discharged. d. A statement of the resident□s appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

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F 623	Continued From page 5 was intact, he had mild depression, he had no behaviors, required extensive assistance of two staff for transfers and toileting. R178 had diagnosis of chronic ulcers on bilateral lower legs with 8 venous/arterial ulcers with application of nonsurgical dressings and ointments. R178 weighed 377 pounds and took a daily antidepressant, antianxiety, anticoagulant, antibiotic, diuretic, and opioid. R178 had been receiving therapy. R178's facility Order Summary Report identified R178's orders to include daily cleansing and dressing of surgical wound site, daily bilateral lower extremity treatment of vinegar solution-soaked gauze for 20 minutes, then cleansing with saline soaked gauze and Calcium AG applied to open areas with dressings to cover, then daily lymphedema compression wraps with cotton barrier between dressings to be applied by therapy and licensed staff daily. A daily treatment to right heel and bottom of foot with dressing to protect. Nursing was to monitor for sepsis daily with vital signs every 4 hours and a progress note and complete a weekly skin assessment on Fridays. R178's current undated, care plan identified chronic venous insufficiency with severe lymphedema in bilateral lower extremities. Staff were to encourage R178 to elevate his legs when sitting or sleeping, encourage good nutrition and hydration. R178 had numerous venous stasis ulcers on his lower extremities that required daily wound care and lymphedema wraps. Nursing was to monitor for signs and symptoms of infection and excessive edema and update the medical provider as needed. R178 had chronic cellulitis of lower extremities requiring daily	F 623	appeal hearing request. e. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. f. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and g. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. The Administrator, Director of Nursing or designee will review and/or develop policy and procedures to ensure timely written notification was provided to the resident and their resident representative as soon as practicable before discharge. Education on the transfer and discharge requirements will be provided to the IDT Management members at the June 28, 2022, IDT meeting and periodically to ensure understanding and compliance. The results of these audits will be reviewed by the Quality Assurance committee to ensure compliance.	

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F 623	Continued From page 6 monitoring and dressing changes. R178 had history of falls due to self-transfer attempts and required 2 staff and a standing lift for safety related to concern of knees buckling. R178's 11/8/21, regional hospital notes identified they had updated the facility related to R178's anticipated discharge after he was deemed medically stable. The notes identified R178 had been admitted for concern of right lower extremity cellulitis (skin infection). He had severe lymphedema and venous statis (poor blood flow in veins) with ulceration and recent infection of the right lateral foot requiring amputation of the 4th and 5th toes. The report identified due to systemic symptoms and wound changes, R178 received a dose of Ceftriaxone. The note further identified R178 had presented to an emergency department (ED) but had left against medical advice before admission and he again presented to the ED yesterday with some systemic symptoms and worsening of the right lower extremity cellulitis. The plan included wound care 3 times daily, IV Vancomycin and Cefepime (antibiotics), pain management and treatment of new skin issues. The facility noted review of the hospital wound care frequency had increased from 1 time a day to 3 times a day since discharge to the hospital. Review of R178's 11/17/21, hospital update notes identified osteomyelitis, stable to discharge criteria had not been met. R178's wound care frequency had decreased to twice a day and as needed for excess drainage or dressing displacement. There were additional skin issues noted in groin and gluteal cleft with twice a day dressing changes and R178 had been refusing treatments. Recommendation for a low air loss	F 623	Completion date will be June 28, 2022.	

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F 623	Continued From page 7	F 623		

mattress and bariatric RoHo cushion with repositioning done at least hourly while in chair. The facility was to consider frequent wound care wrapping schedule at least 12 hours donned overnight with attempts to wrap between cares using a limb sling.

R178's 11/29/21, discharge notice delivered via Certified Mail identified on 11/23/21, the facility could no longer meet R178's needs and therefore was issuing a discharge notice. The notice further identified that on 10/19/21, the facility had discussed alternative placement to better meet R178's needs at which time R178 was in agreement with. The staffing situation had not changed, and the facility was still not able to meet R178's needs. The reason for discharge was identified as: 1) staffing shortage 2) wound care frequency and extensive time involved requiring more than one staff 3) additional skin area concerns with treatments 4) not having the recommended equipment to provide cares and 5) current COVID-19 outbreak status. This notice reached R178 seven days after the identified discharge date of 11/29/21.

Interview on 11/27/22 at 10:19 a.m., with administrator identified that the facilities interdisciplinary team (IDT) reviewed R178's hospital updates on his condition regularly and had even requested additional information but had never received it. When R178 was discharged to the hospital he was getting wound care treatments done once a day and that was taking the licensed nurse and another staff approximately 2 hours to complete as it was very extensive. When the hospital first reached out to us on 11/8/21, about R178 returning to the facility we were in an COVID-19 outbreak, we were short

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F 623	Continued From page 8	F 623		

staffed, there was not contracted staff available to get for assistance, and R178's care needs had increased. She stated we just did not have the means to provide the care R178 required. She further identified the IDT had previously met with R178 prior to his hospitalization to discuss alternative placement due to his extensive wound care needs that he had agreed with.

Review of the 11/23/21, written statement from the Medical Director identified after review of R178 care needs at time of his discharge to the hospital and review of the hospital notes it was identified that R178 required an increase in wound care needs from his previous everyday orders that took a licensed staff and another staff approximately 2 hours to complete already taking away care needs for other residents. The statement further identified the facility was unable to provide the additional care needs due to staff availability and he agreed with the decision of the facility to decline R178's re-admission.

R178's 11/23/21, discharge summary identified R178 had been admitted on 8/23/21 and discharged on 11/23/21. R178 had been discharged to the hospital on 10/29/21 and it was determined the facility would not be able to meet his care needs going forward, as his needs exceed the services the faciity was able to provide. R178 was given notice on 11/23/21.

Review of the 8/10/17, Transfer and Discharge Policy and Procedure identified the facility must permit a resident to return to the facility, and not discharge or transfer a resident from the facility unless 1) discharge was necessary for the resident's welfare and the facility was unable to meet the resident's needs. 2) the resident's health

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F 623	Continued From page 9 had improved, and the resident no longer required the faculties services. 3) Other residents would be endangered related to the resident's behavioral or clinical status. 4) Other resident's health would be compromised. 5) The resident had failed to pay for the stay. 6) The facility closed. The facility may not discharge a resident during an appeal unless other residents would be endangered by not discharging the resident and the facility must document the danger. The facility will provide to the resident and representative a timely notification of the discharge that includes the reason for the discharge. The facility will provide the notice at least 30 days prior to discharge or as soon as possible and document in the resident's medical record the reasons for discharge.	F 623		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R5 and R19), were prohibited from keeping a cigarette lighter on their persons in accordance with the National Fire Protection (NFPA) 101, the Life Safety Code at 19.7.4, when both R5 and R19 identified they both had un-secured smoking materials including lighters in their possession,	F 689	The Smoking Policy and Procedures were revised on June 17, 2022, to ensure residents who smoke are supervised appropriately for safety. All resident who smokes will be assessed for safe smoking and for those residents that have been determined as independent with smoking according to the multidisciplinary smoking	6/29/22

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F 689	Continued From page 10 had a history of unsafe smoking, or were not always cognitive. In addition, R5 was also observed not using a required smoking apron to ensure her safety while smoking unsupervised. Findings include: R5 was admitted to the facility in December 2018 with diagnoses including paraplegia, anxiety disorder, emphysema, respiratory failure with hypoxia, epilepsy, Major depressive disorder, and type 2 diabetes. R5's 3/15/22, discharge return anticipated, Minimum Data Set (MDS) identified she had intact cognition, and she required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene, and supervision when she went off the unit. R5's 9/27/21, Smoking assessment identified a R5 had a history of burns on her clothing, and she had been provided with a smoking apron to prevent burning of her clothing or skin. No additional smoking assessments were identified as having been completed. R5's current, undated care plan identified she was to use a smoking apron and was to have increased supervision if she had symptoms of a Urinary Tract Infection (UTI), which resulted in increased confusion. When R5 was alert and oriented she was able to safely smoke without assistance or supervision, however the facility noted she still required a smoking apron for safety. The care plan identified if R5 was identified with cognitive changes a smoking assessment was to be re-evaluated. Observation/interview on 5/23/22 at 1:56 p.m., R5	F 689	assessment will be allowed to keep their own cigarettes and lighters in their possession. Lock boxes have been purchased and placed in these residents rooms to securely lock lighters within the resident s room. All staff will be re-educated to Smoking Policy and Procedures at the all-staff meeting on June 29, 2022. The Director of Nursing will audit resident s weekly who smoke to determine safety and that proper supervision occurred. The results of these audits will be brought to the quarterly Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring. Completion date of this plan of correction is June 29, 2022.	

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F 689	Continued From page 11	F 689		

reported she smoked cigarettes and went outside to smoke 3-4 times daily. R5 stated she was able to keep both her cigarettes and a rechargeable lighter in her possession all the time. R5 had a power strip located on the surface of her bedside stand with the lighter plugged into the strip. She reported the lighter worked like a car cigarette lighter and demonstrated when she slid the top of the stick open a circular area that glowed red indicting extreme heat and was used to light her cigarette. R5 reported she placed both the lighter and cigarettes in a bag she carried, and then placed her lighter back in the charger as needed. R5 was observed going outside to smoke a cigarette with a fleece blanket across her lap, and wearing a jacket, but she was not wearing a smoking apron. R5 felt she no longer needed to use the apron and "was careful" to drop ash to the side of her wheelchair and had not had any recent incidents of dropping ash on her clothing. R5 was able to transport herself in her wheelchair in the facility, but did have decreased mobility of her right side, and staff assisted her out and into the building when she wanted to go out to smoke.

Observation on 5/24/22, at 10:00 a.m., R5 was outside smoking with her sister in attendance, and was not wearing a smoking apron, as she sat smoking wearing a jacket, had a blanket on her lap, and was not wearing a smoking apron.

Observation on 5/25/22, at 2:00 p.m., R5 was outside smoking and was not wearing a smoking apron as she sat in her wheelchair and her sister was in attendance.

R19's 4/22/22, quarterly MDS identified she was independent with activities of daily living, and had diagnoses of anxiety disorder, depression,

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F 689	Continued From page 12	F 689		

alcohol dependence and had cognitive impairment.

R19's 4/21/22 Smoking assessment identified she was safe to smoke independently.

Observation/Interview on 5/25/22 at 4:00 p.m., with R19 identified she had both her cigarettes and lighter in her possession in her room and that she stored them in an unlocked top drawer of her nightstand. She reported she went outside to smoke early in the mornings between 5:30 a.m. and 6:00 a.m. and then again in the later afternoon or evening.

Interview on 5/24/22 at 10:07 a.m., with registered nurse (RN)-A identified there were four residents in the facility that smoked, and 2 of the 4, (R5 and R19), kept their smoking materials in their rooms which included lighters and cigarettes. RN-A identified smoking assessments were supposed to be completed quarterly and with any change in resident status. The smoking assessments were competed by herself or the director of nursing. RN-A reviewed the record and identified the only smoking assessment which had been completed for R5 was the initial assessment done at the time of admission. She reported assessments should have been completed on a quarterly basis, and following R5's recent hospital discharge dated 3/18/22, when she returned following admission with symptoms of lethargy, decreased orientation, and hypotension consistent with sepsis (severe infection).

Interview on 5/25/22 at 1:53 p.m., licensed practical nurse (LPN)-A identified she was aware R5 and R19 kept their smoking materials in their

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F 689	Continued From page 13 own possession unsecured but was not aware of when smoking assessments were completed or who was responsible for completing them. Interview on 5/26/22 at 12:25 p.m., with the DON identified 2 of 4 residents kept their own smoking materials in their possession which included cigarettes and lighters and these materials were not kept in a secured location. The DON reported she was not aware of the safety issues of unsecured lighters in resident rooms. The DON reported R5's smoking assessment dated 9/27/21 was the most recent assessment that had been completed and the facility policy identified it should have been completed quarterly. Interview on 5/26/22 at 3:24 p.m., with LPN-B identified a smoking assessment was supposed to be completed at the time of admission and quarterly and identified she would access the care plan for updated precautions or interventions. LPN-B reported R5's care plan identified she was supposed to be utilizing a smoking apron when she went out to smoke, and she thought that was what she was doing. Review of the 11/28/16, Smoking Policy and Procedure identified residents would be kept safe when they were smoking and that assessments would be completed at the time of admission, quarterly and with a change in condition. There was no mention how the facility identified lighters were safe to be kept in a residents room unsecured or how residents were deemed safe with a history of unsafe smoking.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/29/22

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F 880	Continued From page 14 §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 §483.70(e) 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:	F 880		

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F 880	Continued From page 15 (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 have a method to ensure active, daily, cumulative surveillance in order to monitor, track, and trend all infections especially infections of COVID-19 . The facility also failed to ensure they had a method to track staff illness and appropriateness to for staff to return to work or enter the building if ill. The facility also failed to increase resident screenings and perform appropriate staff screenings/testing per Centers for Disease Control in the presence of a known	F 880	Gil-Mor has contracted with Pathway Health to provide Infection Control, Prevention, Surveillance and Antibiotic Stewardship education and training to improve our knowledge, competencies and understanding to ensure compliance with Infection Control and Prevention requirements. The contracted consultant will begin training on June 28 □ 29th, 2022. The Director of Nursing or designee reviewed facility policies to	

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F 880	Continued From page 16 COVID outbreak. This had the potential to affect all 27 residents residing in the facility. Findings include: SURVEILLANCE / SCREENING / EMPLOYEE ILLNESS Review of the current, undated facility surveillance revealed the facility had only tracked resident infections that were treated with antibiotics. The facility tracking form for collecting data identified the room number, resident name, onset date, signs and symptoms, mental status change, organism, X-ray, treatment and dates, resolved, and a place for comments. Each month in: 1) December 2021, there were no identified infections including the 5 different days staff tested positive for COVID-19. 2) January 2022, there were 3 residents that had been identified with infections that were treated with antibiotics that resolved. There was no mention of the 6 different days staff tested positive for COVID-19. 3) February 2022, there was 1 resident that had been identified with an infection that had been treated with an antibiotic that resolved. There was no mention of the 3 different days staff tested positive for COVID-19. 4) March 2022, there were 5 residents had been identified with an infection 4 had been treated with antibiotics and 1 resident had been hospitalized none with identified resolve dates. 5) April 2022, there were 3 residents that had been identified with an infection and treated with an antibiotic with none of the residents identified with resolve dates. 6) May 2022, there was 1 resident that had been identified with an infection and treated with	F 880	ensure they contain all components of the Infection Control Program, including daily cumulative tracking and trending of all illnesses in the facility, implemented droplet precautions to mitigate COVID-19 transmission and ensure the appropriate us of PPE, to prevent staff from working with symptoms of COVID-19 and that cares are performed appropriately and timely. The DON or designee will educate all staff on updated policies and procedures and will perform audits to ensure the policies are being followed. The audit results will be brought to the Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.	

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	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

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F 880	Continued From page 17	F 880		

antibiotic with no identified resolve date. There was no mention of the 7 residents or 3 staff that tested positive for COVID-19.
There had been no tracking of any potential viral-like infections, illnesses, or infections not treated with an antibiotic. There was lack of evidence that the facility reviewed or investigated the developed of infections for potential causes. There was a lack of an analysis that identified the infections for trends, identified comparisons, tracking for clusters within the facility, education, or implementation of interventions to reduce or prevent infections. Additionally there had been no tracking of staff illness for analysis of any correlation between staff and resident illnesses.

Interview on 5/25/22 at 1:30 p.m., with RN-A identified when staff called in ill for their shift as a charge nurse she was unable to ask what the staff symptoms were. She revealed the only way she would know if they had COVID-19 symptoms was if the staff were to disclose that information when they called in ill for there shift. She revealed that staff screened themselves in at the beginning of their shift if they were trained. RN-A agreed without knowing staff symptoms there was no way to track that they were okay to return to work after being ill.

Review of the May 2022 handwritten resident screening forms done once daily by staff identified signs and symptoms were recorded by staff marking "yes" or "no" and taking a resident's temperature and oxygen levels. Various s/s of potential COVID could be seen throughout, however, on 5/7/22, when R2 was found to be positive for COVID, no signs or symptoms were recorded. Multiple s/s began appearing on the screenings. When compared to the facility

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F 880	Continued From page 18	F 880		

surveillance as noted above, no tracking or trending was done to correlate the potential source of the infection, such as staff exposure, nor was there any corroboration or increased s/s screening to identify early s/s of infection that may occur more than once per day.

Review of staff illness call in slips, staff schedules, and staff COVID reports identified on:
1) 5/7/22, restorative aide (RA)-A called in with a report of a sick child. No details were given as to if RA's child had s/s of potential COVID, identifying a possible high risk exposure to RA-A.
2) 5/8/22, nurse aide (NA)-J left work early due to "not feeling well". There was no indication NA-J was thoroughly assessed to identify if she had s/s of COVID. trained medication aide (TMA)-D was ill with "COVID symptoms. Told to go get tested". No information on TMA-D's illness was recorded to determine when and where TMA-D was to be tested, or if she was to be held off the schedule due to her s/s.
3) 5/11/22, business office (BOM)-B called in with s/s of a "sinus infection". There was no information to identify if BOM-B was advised to seek testing and wait for confirmation prior to returning to work the next day for approximately 3 hours before she tested herself for COVID-19 and was found to be positive.
4 more staff call-ins were identified for May 2022. None of that information was noted to be included in the facility surveillance upon comparison.

Interview and surveillance, staff illness screenings, and resident and staff screenings on 5/25/22 at 3:51 p.m., with RN-B infection preventionist revealed that only residents being treated with an antibiotic were being tracked for the facility surveillance. She confirmed that there

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	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

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F 880	Continued From page 19 had been no viral infections logged or tracked and agreed that should also be tracked to identify an outbreak or clusters. Neither resident or staff COVID-19 screening information had ever been reviewed by her or anyone else that she was aware of but confirmed the data should be reviewed and monitored in order to identify potential outbreak concerns and to ensure if symptoms were identified they were acted upon. The staff illness had not been tracked however, there were call in slip that should be filled out by the charge nurse taking the call. She revealed those call in slip went directly the the administrator and she had never reviewed them before. The charge nurse should be asking about signs and symptoms when staff call in for illness and that should be monitored to ensure staff with potential signs and symptoms of COVID-19 are not entering the building without being cleared to return to work first. She revealed the medical secretary had called in ill on 5/11/22 and then returned to work on 5/12/22, stating she was in the building for a couple hours prior to testing positive. RN-B agreed BOM-B should not have been allowed to return to work. The criteria to return to work for unvaccinated staff included to be out for 5 or 6 days and at that time if staff felt better they would test prior to returning to work. RN-B agreed allowing staff to come into the building to test was not a good. She confirmed there had been no tracking or monitoring of staff illness revealing this process needed to be revised. Interview on 5/25/22 at 5:14 p.m., with the director of nursing who agreed that the facility did not have adequate surveillance and that there had been no tracking of staff illness.	F 880		

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F 880	Continued From page 20 Review of the 2000, Infection Surveillance policy revealed ongoing and routine surveillance as the beginning of an infection prevention program. Surveillance was to assist in identifying possible infections or communicable diseases before they could spread and cause a potential outbreak. The infection preventions should collect and review data on an ongoing basis for signs and symptoms of infections and analyze the information to monitor for trends and identify opportunities to implement an action plan to improve cares and process's. Review of the 2000, Employee Illness policy identified employees who showed s/s of were to consult with the charge nurse or RN-B at that time, and were to consult with RN-B prior to being allowed to return to work. Review of the 2000, Infection Prevention and Control Interim Policy for Suspected or Confirmed COVID-19 policy identified the facility was to promptly determine exposure, identify resident and staff illness and act upon them to prevent and mitigate COVID-19.	F 880		
F 881 SS=F	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 includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced	F 881		7/1/22

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F 881	Continued From page 21 by: Based on interview and document review the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use, and resistance. This had the potential to affect any resident who had an infection requiring an antibiotic. Findings include: Interview on 5/25/22 at 3:51 p.m., with RN-B the facilities infection preventionist (IP) confirmed the facility had no antibiotic stewardship program. She further identified it had been discussed previously at the Quality Assurance Committee (QAPI) meeting but never implemented since she has been there. She revealed that the facility had a large book from Pathways with policies and procedure for antibiotic stewardship and infection control but none of them had been implemented. Interview on 5/25/22 at 11:48 a.m., with director of nursing (DON) identified the facility had a general infection control and antibiotic stewardship policy. She revealed the general policy needed to be "tailored to the facility". She confirmed there was no protocol for antibiotic stewardship confirming that needed to be corrected. Review of undated, Antibiotic Stewardship policy identified the core elements of Antibiotic Stewardship in long term care included 1) leadership 2) accountability 3) drug expertise 4) action 5) tracking 6) reporting and 7) education. The facility required a strong communication system between nursing staff and prescribing practitioners. The program should include tracking and reporting of antibiotic use and	F 881	Gil-Mor Manor contracted with Pathway Health to provide education and training on Infection Control and Prevention as well as Antibiotic Stewardship to our Director of Nursing and Infection Preventionist. Susan Rolfes, MSN RN consultant conducted a facility tour, provided education and training, review of policies and procedures on June 28-29, 2022, to bring our infection prevention and control and antibiotic stewardship programs into compliance with regulations. See below for the agenda for training. Infection Control Training Agenda 06/29/2022 ¿ Review of Infection Control Manual ¿ Infection Control Practices ¿ Active Surveillance o All infection including those without antibiotic ¿ Tracking and Trending ¿ Outbreak Management Antibiotic Stewardship ¿ Criteria for Infection Report ¿ Monthly Infection Control Log ¿ Antibiotic Time Out ¿ Individual Antibiotic Use Tools ¿ Antibiotic Use Audit Tool ¿ Mapping of Infections ¿ Calculating % infection rate ¿ Nurses and Practitioner Antibiotic Stewardship Education Training Completed By: Susan M Rolfes MSN, RN Pathway Health Consultant	

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F 881	Continued From page 22 outcomes in order to identify patterns. The policy identified when a resident was suspected of having an infection, the nurse would assess the resident and communicate to the provider, the facility could reference "McGeer Criteria", and ensure documentation of the diagnosis, medication, dose, route, and duration for any medication. The policy included antibiotic use audit tools for appropriate antibiotic use, a tracking log, and multiple other identified resources.	F 881	Attendees: Dawn Allen, Director of Nursing Tracy Elsing, RN-Infection Preventionist The DON, Infection Preventionist or designee will began performing audits by 07/01/2022 as required in this plan of correction to ensure the policies and procedures are being followed. The results of these audits will be brought to the quarterly Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Completion date will be July 1, 2022.	
F 883 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 the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		7/1/22

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F 883	Continued From page 23 (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 offer Pneumococcal Vaccinations, the pneumococcal conjugate vaccine (PCV13,	F 883	Section 7: Life Safety Vaccination Policy and Procedures were reviewed and updated on June 16, 2022. Vaccination is	

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F 883	Continued From page 24 Prevnar 13) and pneumococcal polysaccharide vaccine (PPSV23) upon admission for 1 of 5 residents (R26) reviewed. Additionally, the facility failed to review and update their Vaccination Influenza and Pneumococcal Policy yearly. Findings include: R26's Admission Record printed 5/27/22, identified R26 had been admitted to the facility on 3/14/22. R26's Minnesota Immunization Information Connection (MIIC) vaccination status identified, R26 had no documented pneumococcal vaccinations. R26's facility medical record lacked evidence that a consent or decline for the pneumococcal vaccination had obtained. Review of R26's progress notes had no mention that R26's vaccination status had been reviewed and/or offered and declined. Interview on 5/26/22 at 10:46 a.m., with director of nursing (DON) identified that the facility logs into the Minnesota Immunization Information Connection (MIIC) system to review vaccination status of all new admission. After MIIC review if the resident was missing the pneumococcal or influenza vaccine the facility would offer that. She revealed that the facility had on their standing orders pneumococcal and influenza vaccination that they could provide. She confirmed R26 had no documentation that she had been provided risk and benefit of the pneumococcal vaccination or that she had declined the vaccination. Additionally, she confirmed that it was the facility policy to offer the pneumococcal vaccination upon admission if a resident did not have.	F 883	part of our standard admission process and is offered upon admission and education is provided about the benefits and risks of vaccinations to residents and/or their representatives. A consent to receive or decline will be obtained during the admission process for vaccinations. Education on the updated policy and procedures were provided at the all-staff meeting held on June 29, 2022, staff meeting. Gil-Mor Manor contracted with Pathway Health to provide education and training on Infection Control and Prevention as well as Antibiotic Stewardship to our Director of Nursing and Infection Preventionist. Susan Rolfes, MSN RN consultant conducted a facility tour, provided education and training, review of policies and procedures on June 28-29, 2022, to bring our infection prevention and control and antibiotic stewardship programs into compliance with regulations. The DON or designee will conduct audits by 07/01/2022 and weekly as required in this plan of correction to ensure the policies and procedures are being followed for resident vaccinations upon admission. The results of these audits will be brought to the quarterly Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Completion date is July 1, 2022.	

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F 883	Continued From page 25 Review of the 10/25/16, Vaccination Influenza and Pneumococcal Policy and Procedure identified the goal was to assist in the prevention of influenza and pneumonia. The facility would review new residents' vaccination records and implement their standing orders to offer the pneumococcal and influenza vaccinations based on CDC recommendations. The facility has made vaccination a standard part of their admission process with vaccinations being offered upon admission. The facility will provide education about the benefits and risks of vaccinations to residents and/or their representatives. A consent to receive or decline will be obtained during admission process for vaccinations. Review of Center for Disease Control and Prevention (CDC) recommends pneumococcal vaccination for adults 65 years and older. Administer PPSV23 and 1 time dose of PCV13 in 1 year. The CDC further recommends giving 1 dose of PCV15 or PCV20.	F 883		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information;	F 885		7/6/22

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F 885	Continued From page 26 (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report to residents, representatives, and families suspected or confirmed COVID-19 by 5:00 p.m., the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other. Findings include: Review of staff positive COVID-19 results identified 6 staff tested positive during the month of December 2021, 12 staff tested positive in month of January 2022, 3 staff tested positive in the month of February 2022, and 3 staff currently have tested positive in month of May 2022. Review of resident positive COVID-19 results for May 2022, 1 resident tested positive on 5/7/22, 4 residents tested positive on 5/8/22, and 2 residents tested positive on 5/10/22. Interview on 5/24/22 at 11:58 a.m., with registered	F 885	In order to widen Gil-Mor's scope of communication for confirmed COVID infections to residents, representatives, and family, we will broaden our methods of communicating that may include signage at entrances/exits, letters, emails, phone calls, COVID-19 information update put on the Gil-Mor Facebook site and Gil-Mor website, and/or recorded messages for receiving calls. This will ensure that the information will reach those that we are required to notify. These notifications will be provided by 5:00pm the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. The Infection Preventionist will utilize COVID-19 outbreak checklist in order to ensure that all steps have been completed and reporting conducted as required. A letter will be given to residents and mailed to their representatives educating them on	

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F 885	Continued From page 27 (RN)-B identified she was the infection preventionist. She revealed that residents and families were notified of positive cases in the nursing home via the facility Facebook page. The administrator had been posting information on the Facebook page. She revealed the notice used to go out in a large group text message but somehow that ended. She was unaware of how families or residents who did not have Facebook were notified but the facility always notified family if their loved one tested positive. She was unaware if residents and families were notified of positive staff cases. Review of the current facility Facebook page identified on 5/8/22, a notice was posted the facility was experiencing a COVID-19 outbreak and they were encouraging visitors to not visit at that time. If visitors choose to visit during that outbreak visits will be restricted to the resident room only. They apologized for having to restrict visitors especially on Mother's Day, but our resident's health and safety are our top priority. There was a reminder that essential caregivers are defined as facility staff under the policy definition and follow staff testing protocols and PPE requirements. There was a thank you for your patience and understanding, signed by the administrator. Additionally, there was a Facebook post on 5/13/22, that the regional ombudsman expressed that several people have had some confusion and/or concerns during our recent covid outbreak and she asked the facility to post an update: The post identified on 5/8/22, one resident tested positive for COVID-19 and the facility testing protocol was implemented for facility-wide testing of all residents. By 5/10/22 there were 7 residents who tested positive. With the outbreak, the Minnesota Department of	F 885	the methods of communication Gil-Mor will utilize to communicate and update them on an outbreak. Gil-Mor Manor contracted with Pathway Health to provide education and training on Infection Control and Prevention as well as Antibiotic Stewardship to our Director of Nursing and Infection Preventionist. Susan Rolfes, MSN RN consultant conducted a facility tour, provided education and training, review of policies and procedures and June 28-29, 2022, to bring our infection prevention and control and antibiotic stewardship programs into compliance with regulations. See below for the agenda for training. Infection Control Training Agenda 06/29/2022 ¿ Review of Infection Control Manual ¿ Infection Control Practices ¿ Active Surveillance o All infection including those without antibiotic ¿ Tracking and Trending ¿ Outbreak Management Antibiotic Stewardship ¿ Criteria for Infection Report ¿ Monthly Infection Control Log ¿ Antibiotic Time Out ¿ Individual Antibiotic Use Tools ¿ Antibiotic Use Audit Tool ¿ Mapping of Infections ¿ Calculating % infection rate ¿ Nurses and Practitioner Antibiotic Stewardship Education	

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F 885	Continued From page 28 Health (MDH) and Infection Control Assessment and Response team (ICAR) followed up with the facility to discuss the facilities infection prevention plan. At that time, it was decided to prevent any additional potential risk of spread of COVID-19 to other residents the facility would temporality put on hold communal dining by serving meals in residents' rooms and provide activities from residents in their rooms. Through contact tracing it was identified that the first exposure likely occurred while on an outing outside of the facility, and that the following exposures likely occurred during communal dining and activity events. There had been no additional notification via Facebook of the 4 residents who tested positive on 5/8/22 or the 2 that tested positive on 5/10/22. No other notifications of positive staff with COVID-19 in December 2021, January 2022, February 2022, or the most recent staff positive results on 5/12/22, 5/19/22, and 5/23/22. Interview on 5/27/22 at 10:19 a.m., with administrator identified residents and families were notified of positive COVID-19 cases via the facilities Facebook page but should be also calling families without Facebook access. She confirmed the facility had not been provided notice following each additional positive case or when staff tested positive for COVID-19. Review of undated, Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19) policy identified reporting and communication to residents, their representatives and families would be by 5:00 p.m., the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new onset of	F 885	Training Completed By: Susan M Rolfes MSN, RN Pathway Health Consultant Attendees: Dawn Allen, Director of Nursing Tracy Elsing, RN-Infection Preventionist The Director of Nursing or designee will conduct outbreak audits to ensure that all required reporting has been done and will report findings quarterly to the Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Completion date July 6, 2022.	

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	245594	A. BUILDING _____ B. WING _____	C 05/27/2022

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F 885	Continued From page 29 respiratory symptoms occurring within 72 hours of each other. The information will not include identification of personal information but would identify mitigating actions that have been implemented.	F 885		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that	F 886		6/29/22

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F 886	Continued From page 30 is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure COVID-19 testing occurred immediately for all residents and staff following an identified positive COVID-19 case regardless of vaccination status. Findings include:	F 886	Gil-Mor Manor has updated the Life Safety Section 7 Policy titled Pandemic □ COVID-19 Coronavirus Emergency Preparedness Policy and Procedures to reflect COVID-19 surveillance practices for residents following an identified positive COVID-19 case in a resident. 1. Residents and staff who have signs	

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F 886	Continued From page 31 The Centers for Medicare and Medicaid Services (CMS) Quality/Survey & Certification Group QSO-20-38-NH memo revised on 3/10/22, identified testing requirements for newly identified COVID-19 positive staff or resident in a facility must test all staff and residents immediately regardless of vaccination status. Routine testing of staff, who are not up to date, should be based on the extent of the virus in the community. Staff, who are up to date, do not have to be routinely tested. Facilities are to use their community transmission level as the trigger for staff testing frequency according to Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission located in the QSO-20-38-NH memo. Review of the facility COVID-19 testing following COVID-19 positive staff list for the past 5 months and COVID-19 positive residents in month of May identified on: 1) 12/1/21, 12/15/21, and 12/28/21, there was 1 staff who had tested positive on each day (trained medication aide (TMA)-A, former employee (FE)-A, and business office manager (BOM)-A). There was no documentation of any other staff being tested or any residents being tested following any of the positive results. 2) 12/29/21, dietary aide (DA)-C tested positive. Documentation revealed 6 other staff were tested on that day however, no residents had been tested. 3) 12/30/21, laundry aides (LA)-A and LA-B tested positive and documentation revealed that only 14 out of 72 staff were tested following those positive results. 4) 1/6/22, DA-D and TMA-B tested positive. Documentation revealed that only 15 out of 72 staff were tested following those positive results.	F 886	and symptoms of COVID-19 will be tested immediately, regardless of vaccination status. 2. Upon identification of a single new case of COVID-19 in any staff or resident, testing will begin immediately on all residents and staff. 3. Following initial testing, asymptomatic residents with close contact or someone with COVID 19 will receive a series of two COVID 19 tests not earlier than 24 hours and if negative again 5 □ 7 days after exposure. 4. Education will be provided to all licensed staff regarding required COVID -19 testing for all residents and staff following an identified positive COVID-19 case at the June 29, 2022 meeting. 5. The Director of Nursing will review and audit COVID -19 testing post exposure documentation and report findings to the Quality Improvement Committee quarterly. Completion date: 06/29/2022	

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F 886	Continued From page 32 5) 1/13/22, NA-F and DA-E tested positive and documentation revealed that only 15 out of 72 staff were tested following the positive result. 6) 1/14/22, FE-B tested positive. No other testing of staff or residents had been done following the positive result. 7) 1/20/22, NA-G, H-A, NA-H tested positive. Only 9 out of 72 staff were tested following the positive results. 8) 1/21/22, NA-I tested positive. No other testing of staff or residents had been done following the positive result. 9) 1/27/22, cook (C)-A, H-B, and TMA-C tested positive. Documentation revealed that only 12 out of 72 staff were tested following the positive results. 10) 2/10/22, LA-C tested positive. Only 9 out of 72 staff were tested following the positive results. 11) 2/14/22 and 2/17/22, Minimum Data Set (MDS) nurse (MDS-A) and registered nurse (RN)-B tested positive. There was no documentation of any other staff or residents being tested following those positive results. 12) 5/7/22, R2 tested positive. Only 5 out of 72 staff were tested and 1 other resident following the positive results. 13) 5/8/22, R4, R5, R9 and R25 had tested positive. Only 7 out of 72 staff were tested following the positive results. 14) 5/10/22, R3 and R21 tested positive. No other testing of staff or residents had been done following the positive results. 15) 5/12/22, 5/19/22, and 5/23/22, BOM-B, licensed practical nurse (LPN)-B, and activity aide (AA)-A tested positive. There was no documentation of any other staff or residents being tested following any of the positive results. Interview on 5/25/22 at 3:51 p.m., with RN-B the	F 886		

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F 886	Continued From page 33	F 886		

infection preventionist revealed that all residents were not tested immediately after R2 tested positive on 5/7/22. She further revealed that R2 had been symptomatic including congested earlier in the day, but the staff waited until she had arrived for the evening shift to have her test R2. She was unaware why the day shift did not test immediately but confirmed they should have tested R2 when she first started to have symptoms and then should have tested all residents and staff. She further confirmed she had not tested all residents following R2 positive COVID-19 results on 5/7/22, and confirmed in an outbreak status all residents and staff should be tested. During an outbreak she confirmed that all staff without the vaccination should be tested with 2 antigens tests and 1 PCR each week.

Interview on 5/25/22 at 5:14 p.m., with director of nursing (DON) confirmed that the COVID-19 testing for residents and staff following a positive COVID-19 case had not been completed per CMS guidance.

Review of undated, facility COVID-19 Standing Orders identified facility will test 2 times a week depending on the community transmission levels, county positivity rate, facility outbreak status or the facility decision. Residents with identified symptoms will be tested immediately and placed on transmission based precautions (TBP). Outbreak was defined as resident or staff with a positive COVID-19 test which the facility would then test all residents once weekly and staff would be tested twice weekly from the point of last exposure until 14 days if negative results could be achieved. The facility would test according to the community transmission levels or county rates according to CMS and MDH for

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F 886	Continued From page 34 frequency or the facility decision for frequency. The COVID-19 standing orders had no mention of immediately testing all residents and staff following a confirmed positive COVID-19 results.	F 886		
F 888 SS=L	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)	F 888		6/8/22

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F 888	Continued From page 35 (1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;	F 888		

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F 888	Continued From page 36 (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19.	F 888		

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F 888	Continued From page 37 Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement COVID vaccination policies and procedures to ensure appropriate staff COVID-19 vaccination or exemptions for 3 of 72 staff who were not vaccinated nor had they any approved religious or medical exemption. The facility also failed to develop and implement policy and procedures for mitigating potential transmission of COVID for 15 of 72 staff with approved religious exemptions. The facilities failures resulted in 7 of 27 of residents (R2, R3, R4, R5, R9, R21, and R25) contracting COVID-19. The IJ began on 5/7/22 when 1 of 7 residents (R2) became positive for COVID-19 after repeated staff COVID-19 outbreak infections since December 2021. The facility administrator and director of nursing (DON) were notified of the IJ on 5/26/22 at 3:58 p.m., which was identified as a L-WIDESPREAD. The IJ was removed on 5/27/22 at 2:45 p.m., but non-compliance remained at the lower scope and severity of F-WIDESPREAD, no actual harm with potential for more than minimal harm, that is not immediate jeopardy.	F 888	To protect 27 residents residing at Gil-Mor Manor and all Gil-Mor Manor employees from COVID transmission related to unvaccinated staff members Gil-Mor Manor is immediately taking the following steps on 5/27/2022. Implementing an updated Mandatory COVID-19 Vaccination Policy that reflects the following: 1. All existing staff who have not completed the COVID vaccine and do not have a current Religious Exemption on file approved by the Governing Body are required to submit a religious exemption prior to reporting to duty for next scheduled shift. a. To protect the health and safety of residents and co-workers the identified staff members shall wear N95 masks and eye protection pending approval of the submitted exemption. b. The employee will be informed of the outcome of the exemption review process in writing and be instructed on mitigating factors that include wearing N95 masks and eye protection while on	

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F 888	Continued From page 38 Findings include: Review of the facility list of residents with COVID-19 infections identified there was 7 residents with COVID 19 from 5/7/22 to 5/10/22. Review of the staff vaccination data identified the facility had a 90% vaccination rate. There were 72 employee's total. Of those 72, 54 were fully vaccinated, but 3 staff had no vaccine or exemption and were providing direct care to residents, and 15 staff were given religious exemptions. Review of the facility COVID-19 positive staff and residents' lists identified on: 1) 12/1/21, 12/15/21, and 12/28/21, there was 1 staff who had tested positive on each day (trained medication aide (TMA)-A, former employee (FE)-A, and business office manager (BOM)-A) 2) 12/29/21, dietary aide (DA)-C tested positive. 3) 12/30/21, laundry aides (LA)-A and LA-B tested positive. 4) 1/6/22, DA-D and TMA-B tested positive. 5) 1/13/22, NA-F and DA-E tested positive. 6) 1/14/22, FE-B tested positive. 7) 1/20/22, NA-G, H-A, NA-H tested positive. 8) 1/21/22, NA-I tested positive. 9) 1/27/22, cook (C)-A, H-B, and TMA-C tested positive. 10) 2/10/22, LA-C tested positive. 11) 2/14/22 and 2/17/22, Minimum Data Set (MDS) nurse (MDS-A) and registered nurse (RN)-B tested positive. 12) 5/7/22, R2 tested positive. 13) 5/8/22, R4, R5, R9 and R25 had tested positive. 14) 5/10/22, R3 and R21 tested positive.	F 888	duty. Failure to comply with required PPE will result in disciplinary action which may include termination of employment. c. In the event the Exemption from COVID vaccination is not approved the Employee will placed on unpaid administrative leave and offered the COVID vaccine with appropriate vaccination education. If the employee continues to decline the COVID vaccine the employee will be terminated from employment. d. The following actions have been taken for the following employees who are not vaccinated. i. H.S. submitted a Request for Religious Exemption on 05/25/2022. She received education on N95 and Eye Protection the morning of 5/27/2022 ii. M.E. will not be allowed to work until the first dose of COVID vaccine has been administered with proof of vaccination or an Request for Religious Exemption has been completed and submitted. iii. D.T. has been instructed on N95 and the requirement of eye protection at all times the morning of 05/27/2022. Also informed Dana that her exemption was did not indicate a sincere spiritual / religious belief and therefore is not an acceptable exemption. Instructed Dana on COVID vaccination. Dana is not scheduled for the next 3 days and will not be allowed to return to work until COVID vaccine first dose is administered or an appropriate request for deeply held spiritual / religious exemption is requested.	

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F 888	Continued From page 39 15) 5/12/22, 5/19/22, and 5/23/22, BOM-B, licensed practical nurse (LPN)-B, and activity aide (AA)-A tested positive. Observation and interview on 5/24/22 at 11:35 a.m., with NA-D identified she was unvaccinated and had no exemption. NA-D stated she was required to do 1 PCR and 2 rapid tests per week. She was not told she needed to do any enhanced mitigating factors since she was not vaccinated. NA-D was observed only wearing a routine surgical mask. Interview on 5/24/22 at 12:27 p.m., with MDS-A identified during an IDT meeting approximately 1 year ago, the vaccination policy was created. The administrator was responsible to monitor who was vaccinated, any staff with exemptions. She believed the governing body board members were in charge of granting or declining exemptions. Staff not vaccinated or have exemption had no additional measure to mitigate risk to the residents at the facility. Interview and staff vaccination documentation review on 5/24/22 at 1:54 p.m., with the director of nursing (DON) identified the administrator oversaw staff vaccinations. She was unaware of a process to request an exemption or how staff were to request that. She thought the governing body board reviewed requests once a month for staff that requested an exemption. Unvaccinated staff were not required to use any additional measures of mitigating transmission of potential COVID. She had no vaccination information on contracted physicians. The DON confirmed 3 staff were unvaccinated and had no exemptions. Interview on 5/25/22 at 10:20 a.m., with the	F 888	iv. K.K Request for Exemption does not contain a spiritual / religious belief and will receive notice on 5/27/22, regarding the requirement for exemptions. Kathy will also receive instructions on appropriate PPE including N95 masks and eye protection on 5/27/22. 2. Provided education and training to board members that are part of the COVID-19 Exemption Committee on June 8, 2022. Each member signed acknowledging that they received and understand the requirements. 3. New employees who are not vaccinated and request a religious exemption will be provided the form to be completed within 5 days of declining the vaccine. The completed exemption form will be forwarded to the governing body for approval. a. To protect the health and safety of residents and co-workers the new employee shall wear N95 masks and eye protection pending approval of the submitted exemption. b. The employee will be informed of the outcome of the exemption review process in writing. In the event the Exemption from COVID vaccination is approved the employee will be instructed on mitigating factors that include wearing N95 masks and eye protection while on duty. Failure to comply with required PPE will result in disciplinary action which may include termination of employment. c. In the event the Exemption from COVID vaccination is not approved the Employee will placed on unpaid administrative leave and offered the	

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F 888	Continued From page 40 medical director (MD) identified he had not been aware of or been asked to discuss any policies on COVID since his last review 2 years ago at the very beginning of the COVID pandemic. Appropriate policies and procedures were not routinely discussed in Quality Assurance Performance Improvement. The MD was aware the facility had a recent resident outbreak, but was unaware of how many residents had been infected. He was also unaware the facility had had staff outbreak since December 2021. He was unaware the facility had no policy and procedures to ensure staff had appropriate vaccinations, exemptions, or mitigating factors to decrease the potential to spread infection of COVID-19. He was also unaware 3 staff had not been vaccinated or had requested and been granted any type of exemption. Interview on 5/25/22 at 3:51 p.m., with RN-B who was the infection preventionist identified all unvaccinated staff were to be tested with 2 COVID antigen tests and 1 PCR test each week. RN-B was unaware of Centers for Medicare and Medicaid QSO memos and unsure of current CDC guidance related to staff vaccination. She agreed the current policy identified offering vaccination and unvaccinated staff were not required to "do not do anything extra other than the testing" to mitigate transmission of COVID. She was unaware the facility needed to have measures in place for mitigation strategies and a plan to get staff up-to-date on vaccinations. RN-B stated she was new in her role, had received about a week of training..." related to infection control (19 hours). The ICP identified most all of the facility COVID policies had not been reviewed since 2020. The current vaccination policy was created in January 2021	F 888	COVID vaccine with appropriate vaccination education. If the employee continues to decline the COVID vaccine the employee will be terminated from employment. 4. Religious exemptions are reviewed monthly by the Governing Body to determine the exemption is requested for a sincerely held religious belief. a. The Infection Control Practitioner will track all employees who have been granted a religious exemption. b. The Infection Control Practitioner and / or the Director of Nursing Service will audit compliance with appropriate PPE. 5. Requests for Medical Exemptions must be indicating the reasons as to why the COVID -19 vaccine is clinically contraindicated and signed and dated by a licensed practitioner acting within their respective scope of practice. a. Employees with a medical exemption based on a clinical contraindication will be required to wear an N95 mask and eye protection while in the facility. b. The Infection Control Practitioner and / or the Director of Nursing Service will audit compliance with appropriate PPE. 6. Employees will receive education on the Updated Mandatory COVID-19 vaccination policy at a staff meeting called at 1:30pm on 5/27/2022. a. Employees unable to attend the All-Staff meeting will be educated upon reporting to duty by the Charge Nurse. A sign will be posted at the time clock to	

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F 888	Continued From page 41 related to offering vaccines only. RN-B agreed without mitigating factors to prevent transmission, it could be possible staff had infected residents with COVID in May after having weekly staff COVID outbreaks since December 2021. Interview and COVID vaccination policy review on 5/25/22 at 5:14 p.m., with director of nursing (DON) confirmed the facility's current policy and procedure related to COVID vaccinations only noted the facility would offer vaccinations. It had not been updated to include who would need to be vaccinated, how staff would request and exemption, or how exemptions would be approved, nor did it identify mitigating factors for staff who were not vaccinated to prevent the spread of COVID-19. Review of the 1/27/21, COVID Vaccination Policy identified the facility was to offer COVID vaccines to all residents and staff and document any declination. There was no mention of how the facility would assure they met 100% compliance with staff vaccination or exemption, as recommended by the Centers for Disease Control (CDC). The facility policy did not include a process for implementation of additional precautions to mitigate transmission and spread for those staff unvaccinated, and a method to ensure the facility maintained documentation of who was vaccinated or had received approval for exemption. There was also no process for a contigency plan for those staff who were not fully vaccinated, or how staff would received boosters as recommended by CDC to ensure staff were up-to-date. Further, the policy did not address how the facility was to identify approval or denial of exemptions for staff not wanting vaccination. The IJ was removed on 5/27/22 at 2:45 p.m.,	F 888	immediately report to the Charge Nurse for Education. b. The Charge Nurse□s will receive a copy the policy and information to provide employees on 05/27/2022 and upon arrival to next scheduled shift by the Director of Nursing Service. c. Employees will be asked to sign a form indicating they have received and understand the updated information in the Mandatory COVID □ 19 Vaccination Policy and PPE requirements. 7. The Infection Control Practitioner, Director of Nursing and Charge Nurse will audit the appropriate use PPE for unvaccinated staff who are pending COVID 19 exemption approval or have been granted an exemption from the COVID vaccine every shift until June 7 then audited weekly until June 14 and then every 2 weeks until July 12. Ongoing compliance with PPE will be monitored monthly. Failure to comply with PPE will be reported to the Director of Nursing. 8. Completion date: 06/08/2022	

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F 888	Continued From page 42 when it could be verified by observations, interviews, and document review, the facility had updated existing policies to ensure staff vaccination or exemption were corrected, additional measures were implemented and observed having been put into place to ensure staff who were not vaccinated were using processes to mitigate transmission.	F 888		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/23/22 through 5/27/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the	2 000		

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2 000	Continued From page 1 date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5594023C MN78684, H5594023C MN78518, with a licensing order issued at 1925. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R5 and R19), were prohibited from keeping a cigarette lighter on their persons in accordance with the National Fire Protection (NFPA) 101, the Life Safety Code at 19.7.4, when both R5 and R19 identified they both had un-secured smoking materials including lighters in their possession, had a history of unsafe smoking, or were not always cognitive. In addition, R5 was also observed not using a required smoking apron to	2 830	The Smoking Policy and Procedures were revised on June 17, 2022, to ensure residents who smoke are supervised appropriately for safety. All resident who smokes will be assessed for safe smoking and for those residents that have been determined as independent with smoking according to the multidisciplinary smoking assessment will be allowed to keep their own cigarettes and lighters in their possession. Lock boxes have been	6/29/22

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2 830	Continued From page 3 ensure her safety while smoking unsupervised. Findings include: R5 was admitted to the facility in December 2018 with diagnoses including paraplegia, anxiety disorder, emphysema, respiratory failure with hypoxia, epilepsy, Major depressive disorder, and type 2 diabetes. R5's 3/15/22, discharge return anticipated, Minimum Data Set (MDS) identified she had intact cognition, and she required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene, and supervision when she went off the unit. R5's 9/27/21, Smoking assessment identified a R5 had a history of burns on her clothing, and she had been provided with a smoking apron to prevent burning of her clothing or skin. No additional smoking assessments were identified as having been completed. R5's current, undated care plan identified she was to use a smoking apron and was to have increased supervision if she had symptoms of a Urinary Tract Infection (UTI), which resulted in increased confusion. When R5 was alert and oriented she was able to safely smoke without assistance or supervision, however the facility noted she still required a smoking apron for safety. The care plan identified if R5 was identified with cognitive changes a smoking assessment was to be re-evaluated. Observation/interview on 5/23/22 at 1:56 p.m., R5 reported she smoked cigarettes and went outside to smoke 3-4 times daily. R5 stated she was able to keep both her cigarettes and a rechargeable lighter in her possession all the time. R5 had a	2 830	purchased and placed in these residents rooms to securely lock lighters within the resident s room. All staff will be re-educated to Smoking Policy and Procedures at the all-staff meeting on June 29, 2022. The Director of Nursing will audit resident s weekly who smoke to determine safety and that proper supervision occurred. The results of these audits will be brought to the quarterly Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring. Completion date of this plan of correction is June 29, 2022.	

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2 830	Continued From page 4 power strip located on the surface of her bedside stand with the lighter plugged into the strip. She reported the lighter worked like a car cigarette lighter and demonstrated when she slid the top of the stick open a circular area that glowed red indicting extreme heat and was used to light her cigarette. R5 reported she placed both the lighter and cigarettes in a bag she carried, and then placed her lighter back in the charger as needed. R5 was observed going outside to smoke a cigarette with a fleece blanket across her lap, and wearing a jacket, but she was not wearing a smoking apron. R5 felt she no longer needed to use the apron and "was careful" to drop ash to the side of her wheelchair and had not had any recent incidents of dropping ash on her clothing. R5 was able to transport herself in her wheelchair in the facility, but did have decreased mobility of her right side, and staff assisted her out and into the building when she wanted to go out to smoke. Observation on 5/24/22, at 10:00 a.m., R5 was outside smoking with her sister in attendance, and was not wearing a smoking apron, as she sat smoking wearing a jacket, had a blanket on her lap, and was not wearing a smoking apron. Observation on 5/25/22, at 2:00 p.m., R5 was outside smoking and was not wearing a smoking apron as she sat in her wheelchair and her sister was in attendance. R19's 4/22/22, quarterly MDS identified she was independent with activities of daily living, and had diagnoses of anxiety disorder, depression, alcohol dependence and had cognitive impairment. R19's 4/21/22 Smoking assessment identified she was safe to smoke independently.	2 830		

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2 830	Continued From page 5 Observation/Interview on 5/25/22 at 4:00 p.m., with R19 identified she had both her cigarettes and lighter in her possession in her room and that she stored them in an unlocked top drawer of her nightstand. She reported she went outside to smoke early in the mornings between 5:30 a.m. and 6:00 a.m. and then again in the later afternoon or evening. Interview on 5/24/22 at 10:07 a.m., with registered nurse (RN)-A identified there were four residents in the facility that smoked, and 2 of the 4, (R5 and R19), kept their smoking materials in their rooms which included lighters and cigarettes. RN-A identified smoking assessments were supposed to be completed quarterly and with any change in resident status. The smoking assessments were competed by herself or the director of nursing. RN-A reviewed the record and identified the only smoking assessment which had been completed for R5 was the initial assessment done at the time of admission. She reported assessments should have been completed on a quarterly basis, and following R5's recent hospital discharge dated 3/18/22, when she returned following admission with symptoms of lethargy, decreased orientation, and hypotension consistent with sepsis (severe infection). Interview on 5/25/22 at 1:53 p.m., licensed practical nurse (LPN)-A identified she was aware R5 and R19 kept their smoking materials in their own possession unsecured but was not aware of when smoking assessments were completed or who was responsible for completing them. Interview on 5/26/22 at 12:25 p.m., with the DON identified 2 of 4 residents kept their own smoking	2 830		

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2 830	Continued From page 6 materials in their possession which included cigarettes and lighters and these materials were not kept in a secured location. The DON reported she was not aware of the safety issues of unsecured lighters in resident rooms. The DON reported R5's smoking assessment dated 9/27/21 was the most recent assessment that had been completed and the facility policy identified it should have been completed quarterly. Interview on 5/26/22 at 3:24 p.m., with LPN-B identified a smoking assessment was supposed to be completed at the time of admission and quarterly and identified she would access the care plan for updated precautions or interventions. LPN-B reported R5's care plan identified she was supposed to be utilizing a smoking apron when she went out to smoke, and she thought that was what she was doing. Review of the 11/28/16, Smoking Policy and Procedure identified residents would be kept safe when they were smoking and that assessments would be completed at the time of admission, quarterly and with a change in condition. There was no mention how the facility identified lighters were safe to be kept in a residents room unsecured or how residents were deemed safe with a history of unsafe smoking. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure residents who smoke not on the smoke-free campus are supervised appropriately for safety. The administrator or designee should also ensure if smoking is allowed, residents are supplied with a smoking receptacle to discard cigarettes. The facility should re-educate all staff identified to	2 830		

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2 830	Continued From page 7 policies and procedures, and audit residents who smoke to determine safety and supervision occured. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to have a method to ensure active, daily, cumulative surveillance in order to monitor, track, and trend all infections especially infections of COVID-19 . The facility also failed to ensure they had a method to track staff illness and appropriateness to for staff to return to work or enter the building if ill. The facility also failed to increase resident screenings and perform appropriate staff screenings/testing per Centers for Disease Control in the presence of a known COVID outbreak. This had the potential to affect all 27 residents residing in the facility. Findings include: SURVEILLANCE / SCREENING / EMPLOYEE ILLNESS Review of the current, undated facility	21375	Gil-Mor has contracted with Pathway Health to provide Infection Control, Prevention, Surveillance and Antibiotic Stewardship education and training to improve our knowledge, competencies and understanding to ensure compliance with Infection Control and Prevention requirements. The contracted consultant will begin training on June 28 □ 29th, 2022. The Director of Nursing or designee reviewed facility policies to ensure they contain all components of the Infection Control Program, including daily cumulative tracking and trending of all illnesses in the facility, implemented droplet precautions to mitigate COVID-19 transmission and ensure the appropriate us of PPE, to prevent staff from working with symptoms of COVID-19 and that	6/29/22

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21375	Continued From page 8 surveillance revealed the facility had only tracked resident infections that were treated with antibiotics. The facility tracking form for collecting data identified the room number, resident name, onset date, signs and symptoms, mental status change, organism, X-ray, treatment and dates, resolved, and a place for comments. Each month in: 1) December 2021, there were no identified infections including the 5 different days staff tested positive for COVID-19. 2) January 2022, there were 3 residents that had been identified with infections that were treated with antibiotics that resolved. There was no mention of the 6 different days staff tested positive for COVID-19. 3) February 2022, there was 1 resident that had been identified with an infection that had been treated with an antibiotic that resolved. There was no mention of the 3 different days staff tested positive for COVID-19. 4) March 2022, there were 5 residents had been identified with an infection 4 had been treated with antibiotics and 1 resident had been hospitalized none with identified resolve dates. 5) April 2022, there were 3 residents that had been identified with an infection and treated with an antibiotic with none of the residents identified with resolve dates. 6) May 2022, there was 1 resident that had been identified with an infection and treated with antibiotic with no identified resolve date. There was no mention of the 7 residents or 3 staff that tested positive for COVID-19. There had been no tracking of any potential viral-like infections, illnesses, or infections not treated with an antibiotic. There was lack of evidence that the facility reviewed or investigated the developed of infections for potential causes. There was a lack of an analysis that identified the	21375	cares are performed appropriately and timely. The DON or designee will educate all staff on updated policies and procedures and will perform audits to ensure the policies are being followed. The audit results will be brought to the Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21375	Continued From page 9	21375		

infections for trends, identified comparisons, tracking for clusters within the facility, education, or implementation of interventions to reduce or prevent infections. Additionally there had been no tracking of staff illness for analysis of any correlation between staff and resident illnesses.

Interview on 5/25/22 at 1:30 p.m., with RN-A identified when staff called in ill for their shift as a charge nurse she was unable to ask what the staff symptoms were. She revealed the only way she would know if they had COVID-19 symptoms was if the staff were to disclose that information when they called in ill for there shift. She revealed that staff screened themselves in at the beginning of their shift if they were trained. RN-A agreed without knowing staff symptoms there was no way to track that they were okay to return to work after being ill.

Review of the May 2022 handwritten resident screening forms done once daily by staff identified signs and symptoms were recorded by staff marking "yes" or "no" and taking a resident's temperature and oxygen levels. Various s/s of potential COVID could be seen throughout, however, on 5/7/22, when R2 was found to be positive for COVID, no signs or symptoms were recorded. Multiple s/s began appearing on the screenings. When compared to the facility surveillance as noted above, no tracking or trending was done to correlate the potential source of the infection, such as staff exposure, nor was there any corroboration or increased s/s screening to identify early s/s of infection that may occur more than once per day.

Review of staff illness call in slips, staff schedules, and staff COVID reports identified on: 1) 5/7/22, restorative aide (RA)-A called in with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 10	21375		

report of a sick child. No details were given as to if RA's child had s/s of potential COVID, identifying a possible high risk exposure to RA-A.
2) 5/8/22, nurse aide (NA)-J left work early due to "not feeling well". There was no indication NA-J was thoroughly assessed to identify if she had s/s of COVID. trained medication aide (TMA)-D was ill with "COVID symptoms. Told to go get tested". No information on TMA-D's illness was recorded to determine when and where TMA-D was to be tested, or if she was to be held off the schedule due to her s/s.
3) 5/11/22, business office (BOM)-B called in with s/s of a "sinus infection". There was no information to identify if BOM-B was advised to seek testing and wait for confirmation prior to returning to work the next day for approximately 3 hours before she tested herself for COVID-19 and was found to be positive.
4 more staff call-ins were identified for May 2022. None of that information was noted to be included in the facility surveillance upon comparison.

Interview and surveillance, staff illness screenings, and resident and staff screenings on 5/25/22 at 3:51 p.m., with RN-B infection preventionist revealed that only residents being treated with an antibiotic were being tracked for the facility surveillance. She confirmed that there had been no viral infections logged or tracked and agreed that should also be tracked to identify an outbreak or clusters. Neither resident or staff COVID-19 screening information had ever been reviewed by her or anyone else that she was aware of but confirmed the data should be reviewed and monitored in order to identify potential outbreak concerns and to ensure if symptoms were identified they were acted upon. The staff illness had not been tracked however, there were call in slip that should be filled out by

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GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21375	Continued From page 11 the charge nurse taking the call. She revealed those call in slip went directly the the administrator and she had never reviewed them before. The charge nurse should be asking about signs and symptoms when staff call in for illness and that should be monitored to ensure staff with potential signs and symptoms of COVID-19 are not entering the building without being cleared to return to work first. She revealed the medical secretary had called in ill on 5/11/22 and then returned to work on 5/12/22, stating she was in the building for a couple hours prior to testing positive. RN-B agreed BOM-B should not have been allowed to return to work. The criteria to return to work for unvaccinated staff included to be out for 5 or 6 days and at that time if staff felt better they would test prior to returning to work. RN-B agreed allowing staff to come into the building to test was not a good. She confirmed there had been no tracking or monitoring of staff illness revealing this process needed to be revised. Interview on 5/25/22 at 5:14 p.m., with the director of nursing who agreed that the facility did not have adequate surveillance and that there had been no tracking of staff illness. Review of the 2000, Infection Surveillance policy revealed ongoing and routine surveillance as the beginning of an infection prevention program. Surveillance was to assist in identifying possible infections or communicable diseases before they could spread and cause a potential outbreak. The infection preventions should collect and review data on an ongoing basis for signs and symptoms of infections and analyze the information to monitor for trends and identify opportunities to implement an action plan to improve cares and process's.	21375		

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	00542	A. BUILDING: _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21375	Continued From page 12 Review of the 2000, Employee Illness policy identified employees who showed s/s of were to consult with the charge nurse or RN-B at that time, and were to consult with RN-B prior to being allowed to return to work. Review of the 2000, Infection Prevention and Control Interim Policy for Suspected or Confirmed COVID-19 policy identified the facility was to promptly determine exposure, identify resident and staff illness and act upon them to prevent and mitigate COVID-19. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions to mitigate COVID-19 transmission, and ensure the appropriate use of PPE and prevented from working with symptoms of COVID-19 and cares are being performed appropriately and timely. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights	21925		6/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	C 05/27/2022

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GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21925	Continued From page 13 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to timely notify 1 of 1 residents (R178) with written notification for a facility-initiated discharge. Findings include: Review of the 11/13/21 and 11/19/21, State Agency (SA) reports identified R178 had been discharged to the hospital on 10/29/21 for medical evaluation for osteomyelitis (bone infection). The regional hospital identified R178	21925	All potential transfers or discharges will direst be reviewed and discussed during Gil-Mor Manor's weekly Inter-departmental Team (IDT) Management Meeting. If the decision of the IDT Management Team is to issue a transfer or discharge notice, the social worker will locate placement that will meet the residents needs and the formal notification of transfer or discharge letter will be prepared by the Administrator or Designee. This notice will be hand delivered to the resident and a certified	

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21925	Continued From page 14 was medically stable to return to the facility on 11/8/21. The facility was not agreeable to accept R178's return due to staffing shortages and their inability to meet R178's increased needs. The report alleged R178's needs had remained the same as R178 had been receiving wound care and lymphedema (edema) wraps prior to hospital admission. The report further identified R178 had been provided a bed hold from the facility but the facility had declined his return. R178's Admission Record identified admission date of 8/23/21, with diagnosis of lymphedema, hyperlipidemia, type 2 diabetes mellitus, morbid obesity, major depressive disorder, anxiety disorder, transient cerebral ischemic attack, macular degeneration, hypertension, atherosclerotic heart disease, pulmonary hypertension, atrial flutter, systolic heart failure, venous insufficiency chronic, cellulitis of bilateral lower limbs, chronic ulcers bilateral lower limbs, bilateral osteoarthritis of knee, idiopathic chronic gout, infection and inflammatory reaction due to internal right knee prosthesis sequel, and long term use of anticoagulants. R178's 8/30/21, admission Minimum Data Set (MDS) assessment identified R178's cognition was intact, he had mild depression, he had no behaviors, required extensive assistance of two staff for transfers and toileting. R178 had diagnosis of chronic ulcers on bilateral lower legs with 8 venous/arterial ulcers with application of nonsurgical dressings and ointments. R178 weighed 377 pounds and took a daily antidepressant, antianxiety, anticoagulant, antibiotic, diuretic, and opioid. R178 had been receiving therapy. R178's facility Order Summary Report identified	21925	copy will be mailed to the resident representative(s). Additionally, there will be a progress note entered in PointClickCare listing all the required information, including the reasons for the transfer or discharge in the resident's medical record. The transfer and/or discharge notification letter will provide notification to the resident and the resident's representative(s) of the transfer or discharge that will include the following required contents in writing, in a language and manner they understand. The transfer/notice will include a. The reason for transfer or discharge. b. The effective date of the transfer or discharge. c. The location to which the resident is being transferred or discharged. d. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. e. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. f. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental	

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21925	Continued From page 15 R178's orders to include daily cleansing and dressing of surgical wound site, daily bilateral lower extremity treatment of vinegar solution-soaked gauze for 20 minutes, then cleansing with saline soaked gauze and Calcium AG applied to open areas with dressings to cover, then daily lymphedema compression wraps with cotton barrier between dressings to be applied by therapy and licensed staff daily. A daily treatment to right heel and bottom of foot with dressing to protect. Nursing was to monitor for sepsis daily with vital signs every 4 hours and a progress note and complete a weekly skin assessment on Fridays. R178's current undated, care plan identified chronic venous insufficiency with severe lymphedema in bilateral lower extremities. Staff were to encourage R178 to elevate his legs when sitting or sleeping, encourage good nutrition and hydration. R178 had numerous venous stasis ulcers on his lower extremities that required daily wound care and lymphedema wraps. Nursing was to monitor for signs and symptoms of infection and excessive edema and update the medical provider as needed. R178 had chronic cellulitis of lower extremities requiring daily monitoring and dressing changes. R178 had history of falls due to self-transfer attempts and required 2 staff and a standing lift for safety related to concern of knees buckling. R178's 11/8/21, regional hospital notes identified they had updated the facility related to R178's anticipated discharge after he was deemed medically stable. The notes identified R178 had been admitted for concern of right lower extremity cellulitis (skin infection). He had severe lymphedema and venous statis (poor blood flow in veins) with ulceration and recent infection of	21925	Disabilities Assistance and Bill of Rights Act of 2000 (pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and g. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. The Administrator, Director of Nursing or designee will review and/or develop policy and procedures to ensure timely written notification was provided to the resident and their resident representative as soon as practicable before discharge. Education on the transfer and discharge requirements will be provided to the IDT Management members at the June 28, 2022, IDT meeting and periodically to ensure understanding and compliance. The results of these audits will be reviewed by the Quality Assurance committee to ensure compliance. Completion date will be June 28, 2022.	

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GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21925	Continued From page 16	21925		

the right lateral foot requiring amputation of the 4th and 5th toes. The report identified due to systemic symptoms and wound changes, R178 received a dose of Ceftriaxone. The note further identified R178 had presented to an emergency department (ED) but had left against medical advice before admission and he again presented to the ED yesterday with some systemic symptoms and worsening of the right lower extremity cellulitis. The plan included wound care 3 times daily, IV Vancomycin and Cefepime (antibiotics), pain management and treatment of new skin issues. The facility noted review of the hospital wound care frequency had increased from 1 time a day to 3 times a day since discharge to the hospital.

Review of R178's 11/17/21, hospital update notes identified osteomyelitis, stable to discharge criteria had not been met. R178's wound care frequency had decreased to twice a day and as needed for excess drainage or dressing displacement. There were additional skin issues noted in groin and gluteal cleft with twice a day dressing changes and R178 had been refusing treatments. Recommendation for a low air loss mattress and bariatric RoHo cushion with repositioning done at least hourly while in chair. The facility was to consider frequent wound care wrapping schedule at least 12 hours donned overnight with attempts to wrap between cares using a limb sling.

R178's 11/29/21, discharge notice delivered via Certified Mail identified on 11/23/21, the facility could no longer meet R178's needs and therefore was issuing a discharge notice. The notice further identified that on 10/19/21, the facility had discussed alternative placement to better meet R178's needs at which time R178 was in

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	00542	A. BUILDING: _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21925	Continued From page 17	21925		

agreement with. The staffing situation had not changed, and the facility was still not able to meet R178's needs. The reason for discharge was identified as: 1) staffing shortage 2) wound care frequency and extensive time involved requiring more than one staff 3) additional skin area concerns with treatments 4) not having the recommended equipment to provide cares and 5) current COVID-19 outbreak status. This notice reached R178 seven days after the identified discharge date of 11/29/21.

Interview on 11/27/22 at 10:19 a.m., with administrator identified that the facilities interdisciplinary team (IDT) reviewed R178's hospital updates on his condition regularly and had even requested additional information but had never received it. When R178 was discharged to the hospital he was getting wound care treatments done once a day and that was taking the licensed nurse and another staff approximately 2 hours to complete as it was very extensive. When the hospital first reached out to us on 11/8/21, about R178 returning to the facility we were in an COVID-19 outbreak, we were short staffed, there was not contracted staff available to get for assistance, and R178's care needs had increased. She stated we just did not have the means to provide the care R178 required. She further identified the IDT had previously met with R178 prior to his hospitalization to discuss alternative placement due to his extensive wound care needs that he had agreed with.

Review of the 11/23/21, written statement from the Medical Director identified after review of R178 care needs at time of his discharge to the hospital and review of the hospital notes it was identified that R178 required an increase in wound care needs from his previous everyday

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	00542	A. BUILDING: _____ B. WING _____	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21925	Continued From page 18	21925		

orders that took a licensed staff and another staff approximately 2 hours to complete already taking away care needs for other residents. The statement further identified the facility was unable to provide the additional care needs due to staff availability and he agreed with the decision of the facility to decline R178's re-admission.

R178's 11/23/21, discharge summary identified R178 had been admitted on 8/23/21 and discharged on 11/23/21. R178 had been discharged to the hospital on 10/29/21 and it was determined the facility would not be able to meet his care needs going forward, as his needs exceed the services the faciity was able to provide. R178 was given notice on 11/23/21.

Review of the 8/10/17, Transfer and Discharge Policy and Procedure identified the facility must permit a resident to return to the facility, and not discharge or transfer a resident from the facility unless 1) discharge was necessary for the resident's welfare and the facility was unable to meet the resident's needs. 2) the resident's health had improved, and the resident no longer required the faculties services. 3) Other residents would be endangered related to the resident's behavioral or clinical status. 4) Other resident's health would be compromised. 5) The resident had failed to pay for the stay. 6) The facility closed. The facility may not discharge a resident during an appeal unless other residents would be endangered by not discharging the resident and the facility must document the danger. The facility will provide to the resident and representative a timely notification of the discharge that includes the reason for the discharge. The facility will provide the notice at least 30 days prior to discharge or as soon as possible and document in the resident's medical

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GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21925	Continued From page 19 record the reasons for discharge. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures to ensure timely written notification was provided to the resident and their representative as soon as practicable before discharge. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/26/2022. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/23/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/26/2022**

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GIL-MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

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K 000	Continued From page 2 shelter-in-place strategy. The facility has a capacity of 35 beds and had a census of 27 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		6/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

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K 321	Continued From page 3 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 19.3.6.3.5. These findings could have a patterned impact on the residents within the facility. Findings include: 1) On 05/26/2022 at 12:39 PM, observation revealed that Rooms 16, 19, and 20 were repurposed from resident sleeping rooms to storage rooms. The rooms were over 100 square feet in size and did not have self-closing doors. 2) On 05/26/2022 at 12:44 PM, observation revealed that the storage room adjacent to Room 9 did not latch when tested three out of three times. 3) On 05/26/2022 at 13:11 PM, observation revealed that the old physical therapy was repurposed for storage and was over 100 square feet in size. The room did not have a self-closing door. An interview with the Director of Maintenance verified these findings at the time of discovery.	K 321	On 06/23/2022, we received the supplies needed to repair the items listed under this deficiency tag and the maintenance person fixed all three items as follows. Both rooms 16 and 19 were cleaned and returned them back into resident rooms and installed an automatic closer on the door and it securely latches. The room adjacent to room 9 door handle was loose so the maintenance person took it apart and fastened it back together tightly. The door now securely latches every time. The old physical therapy room was repurposed as a storage room and the maintenance person installed an automatic door closer and the door latches securely. Completion date: 06/23/2022	