



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 19, 2025

Administrator
Avera Morningside Heights Care Center
300 SOUTH BRUCE STREET
MARSHALL, MN 56258

RE: CCN: 245228

Cycle Start Date: September 24, 2025

Dear Administrator:

On September 24, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) and SQC. The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other state deficiencies in your facility whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On September 21, 2025, the situation of immediate jeopardy to potential health and safety cited at F684 was removed.

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(ies) listed below to

the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Avera Morningside Heights Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 24, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

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 an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

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 - Health Regulation Division 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.

APPEAL RIGHTS

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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 19, 2025

Administrator
Avera Morningside Heights Care Center
300 SOUTH BRUCE STREET
MARSHALL, MN 56258

Re: State Nursing Home Licensing Orders
Event ID: 1D7951H1

Dear Administrator:

The above facility survey was completed on 09/24/2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

November 19, 2025

Revised Letter

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: CCN: 245228

Cycle Start Date: September 24, 2025

Dear Administrator:

This letter will replace the letter sent earlier today for clarification of remedies.

On September 24, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) and substandard quality of care (SQC).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On September 21, 2025, the situation of immediate jeopardy to potential health and safety cited at F684 was removed.

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 location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore your facility is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 24, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

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 an "E" tag), i.e., the plan of correction should be directed to:

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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



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November 19, 2025

Revised letter

Administrator

Avera Morningside Heights Care Center
300 SOUTH BRUCE STREET
MARSHALL, MN 56258

Re: Event ID: 1D7951-H1

This letter will replace the letter sent earlier today, November 19, 2025. No state deficiencies should have been cited for this survey.

Dear Administrator:

The above facility survey was completed on September 24, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction."

This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2025	
NAME OF PROVIDER OR SUPPLIER Avera Morningside Heights Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET , MARSHALL, Minnesota, 56258			
(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	
F0000	INITIAL COMMENTS On 9/22/25 through 9/24/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ at F684 began on 9/15/25 at 10:23 p.m., when the facility failed to ensure staff appropriately assessed, monitored, intervened, and timely notified the family after a fall for 1 of 1 resident (R1) who had an unwitnessed fall, with visible facial bruising and potential facial structure abnormalities, that resulted in delayed medical examination by a physician and potential early treatment. R1 was not physically assessed by a physician until approximately 9 hours after the fall, R1 was immediately transferred to the emergency room at the local hospital, where a brain bleed and skull fracture were discovered resulting in serious harm and eventual death. The administrator, and director of nursing (DON) were notified of the IJ on 9/24/25 at 12:34 p.m. The facility had implemented immediate corrective actions beginning 9/18/25 and ending 9/21/25 to prevent recurrence; therefore, the IJ was issued at PAST NON-COMPLIANCE. The above findings constituted Substandard Quality of Care; however NO extended survey was required for the finding of past-noncompliance. The following complaints were reviewed: H52284805C (2618679) with a deficiency cited at F684. 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.		F0000				

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2025	
NAME OF PROVIDER OR SUPPLIER Avera Morningside Heights Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET , MARSHALL, Minnesota, 56258			
(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	
F0000	Continued from page 1		F0000				
F0684 SS = SQC-J	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure staff appropriately assessed, monitored, intervened, and notified the family in a timely manner after a fall for 1 of 1 resident (R1) resulting in a brain bleed and skull fracture causing serious harm and eventual death. The immediate jeopardy (IJ) began 9/15/25 at 10:23 p.m., when the facility failed to ensure staff appropriately assessed, monitored, and intervened after a fall for 1 of 1 resident (R1) who had an unwitnessed fall with visible facial bruising and facial structure abnormalities, that resulted in delayed medical examination by a physician and early treatment. R1 was finally transferred to the emergency room 9 hours post fall to the local hospital, where a brain bleed and skull fracture were discovered resulting in serious harm and eventual death. The facility administrator and director of nursing were notified of the IJ on 9/24/25 at 12:34 p.m. The facility had implemented immediate corrective action beginning 9/18/25 through 9/21/25, to prevent recurrence; therefore, the IJ was issued at PAST NON-COMPLIANCE. Findings include: The initial report to the State Agency (SA) identified on:		F0684	"Past Noncompliance - no plan of correction required"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2025	
NAME OF PROVIDER OR SUPPLIER Avera Morningside Heights Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET , MARSHALL, Minnesota, 56258			
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F0684 SS = SQC-J	Continued from page 2 1. 9/15/25 at 11:23 p.m., trained medication aide/nurse aide (NA)-A went to check on R1 and when she opened door to his room, he was found sitting on the floor in front of his recliner. The lights were on, and his walker was over by the closet. His face was bruised, purple, and he had swelling around his eyes. His nose was bruised and yellow. His fingers were covered with a small amount of red blood, and his thumb fingernail was broken at the tip. He had purple bruising and dry blood on the back of his hand. R1's brief was dry, and he denied having pain and hitting his head. He was alert and oriented to person and time. His neuros were reported as stable after the fall. Registered nurse (RN)-A removed his arm rest protectors from his recliner and educated R1 on using his breaks on his four-wheeled walker. There was no indication in the report staff had contacted a physician or family member for R1 immediately after the fall or sent R1 to the emergency room at the adjacent hospital for medical evaluation. 2. 9/16/25 at 1:15 a.m., R1 began to report a headache and was given as needed (PRN) Tylenol 650 mg via standing orders. RN-A called the E-Care physician (on-call telemedicine physician) to report R1 now had a headache, was vomiting, had increased blood pressure (BP), and was noted to be shaking. The E-Care physician visited with R1 via telehealth (video over computer screen). R1 was vomiting into a trash can and complaining his head hurt. The E-Care provider recommended R1 take Zofran (anti-nausea medication) and wait for the Tylenol to "kick in". R1 was noted to have vomited shortly after taking the Tylenol. There was no indication in the report, that the E-Care provider nor RN-A had identified an emergent situation that indicated potential head injury. 3. 9/16/25 at 3:00 a.m., R1's oxygen level was identified to begin to drop between 86%-89% [oxygen saturation (SpO2)] (92% to 100% is normal range), which was reported to be not his baseline. RN-A then administered an Albuterol nebulizer (inhaled medication) treatment via standing orders at 3:34 a.m.. R1's oxygen increased to 90% SpO2 for 30 minutes but then reverted back to 86%-88% SpO2. RN-A called E-care back at that time to report change a in condition. R1 reported his headache pain was less painful, and he was no longer vomiting. The E-care provider then ordered a chest x ray STAT (immediately), a urinalysis specimen (UA) with culture, and some blood specimens and additional medication orders. There was no evidence that RN-A disclosed the previous E-Care physician's call, order changes, R1's recent fall, or identified the seriousness of the incident and the need to send R1			F0684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2025	
NAME OF PROVIDER OR SUPPLIER Avera Morningside Heights Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET , MARSHALL, Minnesota, 56258			
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F0684 SS = SQC-J	Continued from page 3 to the emergency room for in-person evaluation by a physician. 4. 9/16/25 at 5:00 a.m., a nurse aide reported to RN-A that R1 had begun vomiting again. RN-A then called E-Care again requesting a computerized tomography (CT) scan of his head. The E-Care physician told RN-A since R1 was alert and could read questions (R1 had limited hearing so he was asked to read questions rather than hear them asked) used to assess his cognition, they did not believe R1 needed CT scan of his head and only gave order for an X-ray of his. RN-A then entered the orders from the E-Care physician. There was no mention in the report either the E-Care provider, nor RN-A had yet identified the seriousness of R1's condition. 5. 9/16/25 at approximately 7:30 a.m., when R1's primary care physician (NP-C) arrived, he was notified of R1's fall and asked to evaluate R1. PCP directed staff to send R1 to the ER where a head CT was completed and it was noted there were bilateral skull fractures, bilateral brain bleeds, bilateral hemorrhagic contusions (bleeding and bruising) and a subarachnoid hemorrhage(bleeding in the space below one of the thin layers that cover and protect your brain) in the frontal and temporal (side) lobes and a right parietal intraventricular hemorrhage (bleeding in the cerebral ventricular system). Staff noted the call light was not sounding at the time of the fall. The facility identified R1's care plan had been followed. R1's 7/23/25, quarterly Minimum Data Set (MDS) assessment identified R1 was admitted in December 2022 with diagnoses of dementia, diabetes, anxiety, high blood pressure, insomnia, hearing loss, and anemia. R1's undated, current care plan identified R1 was able to dress himself however, staff were to assist as he allowed. R1 used bilateral grab bars to assist with mobility, positioning, and bed mobility. R1 used a four-wheeled walker and was independent with ambulation. R1 was at risk for falls and staff were to keep his room door open as much as possible, to monitor that his walker was near him, and that he had appropriate footwear on. Staff were to remind him to slow down when walking and check on him every 2 hours. R1's 9/15/25, Fall report identified at 10:23 p.m., a trained medication assistant/nursing assistant (NA)-A had opened the door to R1's room to check on him and found him sitting on floor in front of his recliner.		F0684				

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F0684 SS = SQC-J	Continued from page 4 The lights were on, and his walker was over by his closet. The arm rest protectors that were used on his recliner were found on the floor. R1's face was bruised, and he was noted to have swelling around his eyes and his nose was bruised and yellow. His fingers were covered with a small amount of blood, and his thumb nail was broken at the tip. R1 had denied hitting his head but could not explain why he fell. He was alert and orientated to person and time. His neurological assessment was noted to be within normal limits, and his call light was within reach. Interventions identified were to include hourly checks, discontinue arm rest protectors, and provide education to R1 to place his breaks on his walker when it was not in use. The on-call E-Care (telemedicine physician) was notified at 10:45 p.m.. R1's family member was documented as having been notified on 9/16/25 at 7:00 a.m., (8.5 hours later). R1's 9/15/25, Fall Scene Investigation Report (a huddle with staff on duty at time of fall) identified R1 had not utilized his breaks on his walker and did have shoes on at the time of his fall. The fall occurred next to a transfer surface, and the last time R1 was assisted to the restroom was on 9/15/25, at 8:20 p.m.. R1 was found by staff with facial bruising, had swollen eyes and nose, and had bloody fingers. R1's walker was across the room from him by the closet. Question number 4 on the form, noted: "Did the resident hit head or have unwitnessed fall?" The answer was "yes". The form identified if the answer was "yes", staff were to complete vitals (assessments of blood pressure, pulse, and respirations), and neurological (neuro) checks (assessment of pupils) per protocol at: A) every 15 minutes x 4, B) every 30 minutes x 2, C) every hour x4, D) every 4 hours x 6, then only vitals 2 x day x 3 days. R1's 9/15/25 through 9/16/25, neuro checks identified they were completed at:10:38 p.m., within normal limits. (WNL).10:53 p.m., WNL.11:08 p.m., WNL.11:23 p.m. WNL12:23 p.m., WNL, 1 hour later.1:23 a.m., R1 was documented as having a neuro change of a headache (HA).2:23 a.m., identified R1 had HA, nausea and vomiting (N&V).3:23 a.m., identified R1 continued to have a HA, nausea and vomiting (N&V).4:23 a.m., identified R1 continued to have a HA, nausea and vomiting (N&V).The form lacked evidence RN-A had perform 30-minute neuro checks after the 15-minute checks were completed after 11:23 p.m., x 2, per protocol.		F0684				

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F0684 SS = SQC-J	Continued from page 5 Interview on 9/22/25 at 1:00 p.m., with registered nurse (RN)-A identified NA-A found R1 on the floor during rounds, at approximately at 10:20 p.m. on 9/15/25. R1 was on the floor by his recliner and his walker was over by his closet. R1 had denied he fell, which was “unusual for him” as R1 had fallen before and “gets mad if we find he has fallen”. He was assessed and at the time, and his neuros and vitals were stable. E-Care (Nurse practitioner (NP)-A) was contacted by phone to report the fall and that R1 had facial bruising. Between 1:00 a.m. and 1:30 a.m., on 9/16/25, RN-A recalled R1 started to complain of a HA, and N&V at that time. She then gave R1 Tylenol and called E-Care and spoke to NP-B (different provider) to report his new symptoms. At that time, NP-B decided to see R1 via telehealth video conferencing. R1 complained of his head hurt and he was shaking at the time. RN-A was then directed by NP-B to give him Zofran. RN-A stated, “I thought that was odd” as R1 was shaking and his blood pressure was elevated. “It was a very busy night, and I was overwhelmed”. RN-A had another resident with an IV that was not working, and another resident on another unit, that she needed to straight catheterize (to assist with urination) for another nurse. RN-A called the hospital resource nurse (RN-H) from the adjacent hospital to come and help her with her duties. NP-B was called again when R1’s oxygen levels dropped. RN-A stated she had “just listened” to NP-B and “did what she said”, as it was “so busy that night”. She had asked NP-B for a CT scan of R1’s head which NP-B declined. NP-B was reported to decline RN-A's recommendation, as R1 had been able to “read the questions” RN-A had written out earlier as he was hard of hearing, and his headache had improved. NP-B ordered an X-ray of his facial bones and RN-A took him over to the adjacent hospital's radiology department for the X-ray. RN-A gave report to the oncoming day nurse, the nurse manager (RN-D), and the facility NP (NP-C), who happened to be at the facility early that day (at approximately 7:30 a.m., on 9/16/25). NP-C did assess R1 and had him sent over to the ER immediately. RN-A felt the reason she had not sent R1 over to the ER was because NP-B did not think he need to be seen at the time. RN-A was unaware, she could use her professional judgement to send R1 for medical evaluation. She thought she had to go through E-Care and get a physician’s order to send a resident to the ER. After the fall, the facility did training with all the nurses, and she was made aware a nurse did not need an order to send a resident to the ER. R1 returned from the hospital later that morning and he passed away later that afternoon on 9/16/25.			F0684			

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F0684 SS = SQC-J	Continued from page 6 R1's 9/15/25 at 10:39 p.m., Avel Senior Care (E-Care), Change in Condition written by NP-A, identified RN-A reported R1 was found on floor with marked bruising on face, however, the resident denied hitting his face. It was unknown if R1 hit his head. Neuro assessment identified R1 was alert and orientated x 3 and able to read questions since he was hard of hearing. The NP-A's plan for a non-witnessed fall, was to initiate neuro checks and place him on a fall protocol. Even though he denied head trauma, NP-A ordered staff to monitor his neurological status frequently. NP-A provided the Senior Care Guidance to Monitor for Possible Head Injuries, form that identified signs and symptoms and provided guidance for staff on what to do: Signs and symptoms to watch for included: blacking out/loss of consciousness, headache, dizziness and/or vomiting, new or worsening confusion, trouble recognizing people, unusual sleepiness or difficulty waking up, unusual mood or behavior changes, new or worsening trouble with walking or talking, seizures, bruising behind the ears or around the eyes, and blood or clear drainage from the nose or ear. What to do: identified staff were to monitor the resident for 24-72 hours. It explained: "Early on, there may not be symptoms". If any of these symptoms develop within 24 hours after a head injury, the resident should be urgently evaluated in the emergency room (ER) if that was consistent with their wishes. If a resident had not wanted to be transferred to the ER for evaluation, they should be urgently evaluated by [E-Care]. There was no indication NP-A had identified or followed the written guidance she gave the facility staff on the common lack of symptoms from a head injury as noted above, the facial bruising he already had at the time of the fall, or if she had asked R1 or his family if they desired for R1 to be seen at the ER. R1's 9/16/25 at 1:22 a.m., E-Care provider notification progress note, written by NP-B, identified RN-A called to report R1 was complaining of a headache, nausea, and vomiting. RN-A reported R1 had a fall yesterday. On provider video evaluation, R1 was visualized as awake, responded appropriately, displayed no weakness, followed commands and denied shortness of breath. R1 was anxious and nauseated. NP-B gave new orders for hydroxyzine HCl 25 milligrams (mg) take one tablet by mouth once a day at bedtime for anxiety, and Zofran 4 mg sublingual (SL) every 8 hours one time a day. The hydroxyzine 25 mg order was crossed out and noted (allergy, discontinue (dc)). NP-B also ordered was some blood specimen labs and a UA and urine culture. The order was not electronically signed by NP-B until 9/16/25 at 4:24 a.m. There was no indication in the			F0684			

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F0684 SS = SQC-J	Continued from page 7 progress note NP-B recognized R1's deteriorating condition as a sign of need for immediate evaluation in the ER. R1's 9/16/25 at 4:25 a.m., E-Care provider notification note written by NP-B, identified RN-A called to report resident now had hypoxia (lack of oxygen in the blood). RN-A reported R1's oxygen saturation (O2 sats) were at 90%. RN-A had given a nebulizer treatment however, R1's O2 sats remained at 90%. R1 still had nausea and vomiting. R1 was awake and denied pain, chest pain, or abdominal pain. The telehealth exam identified he "was not in any acute distress". Orders were given to place R1 on oxygen at 2 liters (L) via nasal canula and titrate to keep O2 sats above 92%, get a stat (immediate) chest X-ray, albuterol nebs 2.5 mg every 6 hours as needed for shortness of breath, lpratropium 0.5 mg every 6 hours as needed for shortness of breath, facial X-ray 2 views, and follow up with primary provider (NP-C) in the morning. The order was electronically signed later by NP-B 9/16/25 at 5:08 a.m. There was no indication NP-B identified during the call or telehealth assessment, that R1's condition was worsening or that he needed to be sent to the ER to be physically evaluated with a higher level of care. R1's 9/16/25 at 10:14 a.m., provider note by NP-C who identified R1 had been seen today (time unidentified on the note but reported by staff to be approximately 7:30 a.m.) at staff request, to follow up after an E-Care visit during the night due to a fall where the resident hit his head. There had been a facial X-ray done at this time. No CT scans were completed, and the resident had not been evaluated in the emergency department during the night. R1, while hard of hearing, was cognitively different than normal during the exam. He was unable to answer questions, and his responses are nonsensical at the time. R1's blood pressure was elevated that morning. Staff reported R1 was complaining of a headache, nausea, and vomiting during the night. NP-C assessed R1's head and face injury, and believed R1 needed a higher level of care and possible admission. NP-C consulted with the ER provider MD-B and gave a brief background of what had happened and recommended that R1 be seen in the emergency department. MD-B agreed, and nursing staff brought R1 over to the ER. Signed electronically by NP-C at 10:23 a.m. R1's 9/16/25 at 8:46 a.m., physician (MD-A)'s emergency department (ER) note identified the clinical impression		F0684				

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F0684 SS = SQC-J	Continued from page 8 by the ER physician was R1 suffered a brain bleed with skull fractures. R1's condition was listed as "critical". R1 reported he tripped and fell last night. He had a mild headache but felt it would go away. He had no nausea, no neck pain, no extremity pain and was not on any anticoagulants upon admission. He was alert and oriented and his vital signs were normal. R1 was very hard of hearing but was able to answer questions appropriately. He has periorbital contusions (bruising) bilaterally, with no signs of entrapment. Facial bone computed tomography (CT) was negative. Non-contrast head CT showed multiple significant abnormalities. He had bilateral skull fractures, bilateral subdural hematomas (a pool of blood that can push on the brain), bilateral hemorrhagic contusions (bleeding with bruising) and subarachnoid hemorrhage (bleeding usually from a bulging blood vessel that bursts in the brain (aneurysm) that may lead to permanent brain damage or death if not treated). R1 had left to right subfalcine herniation of 8 millimeters in length (where part of brain tissue moves under a thin membrane that separates the two hemispheres of the brain). [A regional hospital] Neurosurgery was consulted and would accept R1 in a transfer. Keppra was given for seizure prevention, due to subarachnoid hemorrhage. Clinically, R1 declined while at the ER and was not as responsive. After extensive discussion with family, it was unanimously decided not to transfer for aggressive management at that time (related to his deteriorating condition upon his assessment in ER). They would like R1 to be started on hospice and return to the facility. Review of the 8/23/23, National Library of Medicine (NIH) article: Subfalcine Herniation, located at: https://www.ncbi.nlm.nih.gov/books/NBK536946/, identified herniation occurred when brain tissue was displaced within in the cranium. Initial presentation can be a headache. It is common to have headache, nausea, vomiting, or altered mental status. Treatment/management depends on the cause, with an attempt to decrease the intracranial (brain) pressure. Medical treatment may be medication or surgical. Surgical treatment could include ICP monitoring, external ventricular drain, craniotomy to remove a hematoma, or decompressive craniectomy. Brain herniation can cause severe clinical disability or death. Brain herniation is potentially reversible with appropriate and timely therapeutic interventions (by a medical provider). The patient and family should be thoroughly counseled about the possible treatment protocols to help in shared decision-making. A timely diagnosis and management will ultimately benefit the patient and improve the clinical outcome.			F0684			

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F0684 SS = SQC-J	Continued from page 9 Interview on 9/22/25 at 4:30 p.m., with NA-B identified she was working the night of 9/15/25, when R1 fell. NA-A had come to get her to assist with helping R1 up off the floor after the nurse was done assessing him. R1 was able to walk out to the TV room but he was a “little more shaky” than usual. R1’s face was bruised, and his eyes were swollen, and a cold washcloth was placed over his eyes. In her opinion, R1 should have been taken over to the ER, even though he had denied he fell. When she returned to work the next day around 3:00 p.m., she assisted with repositioning R1 who at that time, was unresponsive. Interview on 9/22/25 at 4:40 p.m., with NA-A identified she had entered R1’s room to check on him on the night of 9/15/25 and found him on the floor with his back against the recliner. R1’s walker was across the room by his closet. His hat was on the floor and the closet door was open slightly. R1's right thumb was bleeding. Both of his eyes had bruising and looked “baggy”, like he had hit his face. R1’s right hand was more shaky than normal. The nurse assessed R1, and he was assisted up and he was able to walk out to the TV room. RN-A called the E-Care physician, and they said if R1 was “not complaining”, he was “okay”, but she wished he would have been seen in the ER anyway. NA-A was worried about R1 when her evening shift ended. The nurse manager (RN-D) came out to speak to us the following evening on 9/16/25, as it was a “heart-breaking” event and R1 had passed away. She told staff “If we needed, we could use the employee [assistance] program”. There was a meeting the next day on 9/17/25, with some of the providers and they had some “good ideas”. The medical director was on the phone for the meeting. The meeting was about preventing future similar events. RN-D was aware NA-A was “having a hard time” with R1’s death. NA-A reported she had asked RN-D, if she could have brought R1 over to the ER herself that night, and even if it was not going to help [R1], she would have felt better. RN-D had told her that “technically” she could take a resident to the ER, but the nurse “should call [E-Care] first”. Interview on 9/22/25 at 3:30 p.m., with licensed nurse (LPN)-B identified if a resident had a fall, the nurse would assess the resident and determine if additional treatment was needed. Depending on the nurse’s assessment, the nurse may send the resident over to the ER for evaluation or may call the E-Care provider, if non-emergent, to obtain an order to send a resident to		F0684				

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F0684 SS = SQC-J	Continued from page 10 ER. A nurse did not need an order to send a resident to the ER if the nurse thought (used their professional judgment) they needed to be seen immediately. Further interview on 9/23/25 at 9:10 a.m., with RN-A, identified when E-Care was called, it took a while to get their notes back. She liked to “double check” the provider notes to make sure there were no changes from the oral orders. She noted she could have sent R1 over to the ER when he developed symptoms, but she understood she needed to call E-Care and go through them first. She did feel like R1 should have been sent to the ER, but she felt she needed an order to do that. Staff “had to do as much as possible before sending someone to the ER”. That was “why they had E-Care”. E-Care would assess so “we are not sending residents over unnecessarily”. The facility did do training that we do not need an order to send someone to the ER we can just send if we feel it is needed. She was offered to speak to someone if she needed as she reported she felt “so bad about the outcome” of this resident. Interview on 9/23/25 at 9:53 a.m., with medical director (MD-B) identified she had been notified of the incident. She revealed there were “many parts” contributing to the incident. MD-B was concerned how the providers (NP-A and NP-B) handled the situation and had referred one for peer review. She identified she “supported” a lot of long-term care facilities and had done education with nurses in the past, that they do not need a physician order to send someone to the emergency department. “Unfortunately, there is a belief out there that they need an order”, and they have a hard time sending someone to the ER without one. She would expect anytime there was something “clearly alarming”, the nurse would send a resident to the ER for an evaluation. They do not need an order for that. She had not spoken to the nurse on duty that night (RN-A) but “felt bad for her” as she felt RN-A likely thought she was doing the right thing by reaching out to E-Care for direction. E-Care did “lay eyes” on the resident. She had concerns about the decisions by E-Care that were made. MD-B felt the outcome would not have changed for R1 due to his significant fractures and the family choosing not to pursue aggressive treatment (after discovery of the fractures in the ER) however, she would have expected that conversation to have happened “sooner than it did”. She had completed a thorough review of R1’s medical record and provider notes. The following day she participated in a meeting with the facility and discussed things that lead up to the event and what the facility could do to prevent		F0684				

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F0684 SS = SQC-J	Continued from page 11 events like this from happening again. Interview on 9/23/25 at 11:03 a.m., with director of nursing (DON) identified she had visited with RN-A and educated her that she could send a resident over to the ER anytime she had concerns. RN-A's "intuition" was that "something was wrong", and she hoped now she would feel more empowered to follow her intuition in the future. She would expect a nurse to act on their assessments and critical thinking and send someone to the ER for evaluation if the nurse felt it was needed. She revealed it maybe hard for nurses to "override [decisions by] a provider" and send someone to the ER if that provider did not agree, but at times that might need to be done since the nurse's know the residents better, or if "something was not right". She confirmed R1 should have been seen in the ER immediately but especially after he started to develop symptoms of headache, nausea and vomiting. All licensed nurses were retrained starting on 9/18/25, on E-Care and Emergency room services, ARCC (Ask a question, make a request, voice a concern, use chain of command) and how to use ARCC. Interview on 9/23/25 at 3:53 p.m., with RN-G who was also the facility education nurse, identified she had been the nurse on-call the night of 9/15/25 into 9/16/25. She had not been called by RN-A to come in and assist her "with anything". RN-A had not reached out to her to consult about R1's fall or any concerns she may have had about him developing symptoms. The facility had an internal departmental meeting anytime there was a fall with a major injury or if a resident was having multiple falls. These meeting were to discuss the fall or falls and determine a root cause. Training was provided to all the nurses following R1's event. We encourage our nurses to collaborate with each other all the time and encourage collaboration with the providers. Interview on 9/23/25 at 4:37 p.m., with licensed practical nurse (LPN)-A, identified he worked the night of R1's fall on a different unit. RN-A had come to the unit he was working on at around 3:00 a.m. or 4:00 a.m. to obtain Zofran from the emergency medication kit. RN-A had not asked him to assess R1 however, she had told him that R1 was having nausea and vomiting after having a fall. LPN-A revealed he had advised RN-A to send R1 to the ER because "anyone having a fall and developing symptoms like that should be seen".		F0684				

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(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	
F0684 SS = SQC-J	Continued from page 12 Interview on 9/23/25 at 4:44 p.m., with RN-H (the resource nurse from the attached hospital) identified the facility had called and requested the resource nurse to come and restart an IV that was not working. RN-H reported no facility staff mentioned any other residents. She was just asked to start the IV on another resident. After that, she returned to the hospital. Later interview on 9/24/25 at 9:08 a.m., with the DON identified that the nurse managers all take call. Charge nurses (like RN-A) were able to call for any questions they may have. The facility had a system called Volt (an internal communication system). The nurses could communicate via text messaging or calling different staff through the Volt system. She was unaware RN-A thought she needed a physician order to send a resident to the ER for an evaluation until she had spoken with her. She was unaware that other staff on duty that night (LPN-A) had voiced concerns of R1 to RN-A and had advised they had felt R1 should have been sent to the ER for an evaluation. She also had not been made aware that NA-A had asked a nurse supervisor if they could have advocated for R1 and just have taken him over to the emergency room. A call was placed on 9/24/25 at 11:09 a.m., with a message left for MD-A but a call was not returned. The IJ that began on 9/15/25 was determined to be past noncompliance when it could be verified the facility took steps to correct the deficient practice prior to the survey by reviewing all fall related policies as noted and educating all licensed nursing staff to those policies. The May 2025, Fall Prevention and Management policy identified a fall risk assessment would be completed for each resident upon admission, re-admission, and quarterly. Residents determined to be at risk will have fall interventions incorporated into their care plan. After, a fall a post fall assessment would be completed to determine the root cause to prevent further falls. The nurse was to notify the physician and family at time of fall. The October 2024, LTC Falls and Accidents policy identified upon admission, re-admission, and quarterly		F0684				

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F0684 SS = SQC-J	Continued from page 13 the facility would assess fall risk, elopement risk, and other risk within the facility. The facility would implement interventions for any identified risk on the care plan. For a fall, the nurse was to immediately assess the resident for any injury. A head injury must include vital signs and neurological assessment at least every 4 hours x 4 and then daily for 72 hours. A fall must be investigated for root cause and individualize the residents care plan with interventions. The November 2024, Provider/Medical Services LTC policy identified for a resident that had a change in condition, the medical provider was to be contacted on the condition. For any life threatening or emergency, the resident was to be sent over to the ER for an evaluation. The facility had access to Avel (E-Care) services a telehealth-based system, which offered a virtual face-to-face visit. This system provided access to residents and providers to provide a medical evaluation, treatment and referral as appropriate. This system could be utilized for a change in condition in a non-emergent situation and accessed 24 hours a day with the resident's primary provider (PCP) being notified of the use of Avel virtual services and the resident's condition. The December 2024, Chain of Command and Administrative Call policy identified staff who have identified a problem situation would collaborate with their peers to determine the urgency of the problem. The responsible provider would be contacted for clarification. If the problem remained unresolved, the staff were to seek guidance of the LTC charge nurse. The charge nurse would contact the responsible provider. If the concern continues to be unresolved and there was an immediate risk to the resident care and safety, the charge nurse was to contact the LTC leader on-call if on a weekend, or the director of nursing on a weekday. The findings would be reviewed and if needed, the LTC leader on call or administrator would call for further clarification and discussion. If the issue remains unresolved, the administrator would be contacted and they would notify the chief medical officer, if needed, for assistance. The undated, E-Care and Emergency Room Services policy identified for a resident experiencing an injury or illness, the nurse was to assess and determine the best course of action for the resident. Staff were to address E-Care services with the resident and family. If staff were unable to contact family and/or resident			F0684			

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F0684 SS = SQC-J	Continued from page 14 was unable to make their needs known, staff had the right to send the resident to the emergency room. The nurse may contact E-Care for all non-emergent needs to confer with an on-call provider. The nurse had a right to utilize the emergency department based on their clinical judgement and assessment. A physician's order was not required to send a resident into the emergency room for evaluation. If a nurse was in doubt about whether to pursue further medical care, they were to collaborate with another nurse.			F0684			

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20000	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 9/22/25 through 9/24/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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20000	Continued from page 1 The following complaints were reviewed: H52284805C (2618679) with a licensing order issued at 20830. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. 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 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.		20000				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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		20830				

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20830	Continued from page 2 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure staff appropriately assessed, monitored, intervened, and notified the family in a timely manner after a fall for 1 of 1 resident (R1) resulting in a brain bleed and skull fracture causing serious harm and eventual death. Findings include: The initial report to the State Agency (SA) identified on: 1. 9/15/25 at 11:23 p.m., trained medication aide/nurse aide (NA)-A went to check on R1 and when she opened door to his room, he was found sitting on the floor in front of his recliner. The lights were on, and his walker was over by the closet. His face was bruised, purple, and he had swelling around his eyes. His nose was bruised and yellow. His fingers were covered with a small amount of red blood, and his thumb fingernail was broken at the tip. He had purple bruising and dry blood on the back of his hand. R1's brief was dry, and he denied having pain and hitting his head. He was alert and oriented to person and time. His neuros were reported as stable after the fall. Registered nurse (RN)-A removed his arm rest protectors from his recliner and educated R1 on using his breaks on his four-wheeled walker. There was no indication in the report staff had contacted a physician or family member for R1 immediately after the fall or sent R1 to the emergency room at the adjacent hospital for medical evaluation. 2. 9/16/25 at 1:15 a.m., R1 began to report a headache and was given as needed (PRN) Tylenol 650 mg via standing orders. RN-A called the E-Care physician (on-call telemedicine physician) to report R1 now had a headache, was vomiting, had increased blood pressure (BP), and was noted to be shaking. The E-Care physician visited with R1 via telehealth (video over computer screen). R1 was vomiting into a trash can and complaining his head hurt. The E-Care provider recommended R1 take Zofran (anti-nausea medication) and wait for the Tylenol to "kick in". R1 was noted to have vomited shortly after taking the Tylenol. There was no		20830				

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20830	Continued from page 3 indication in the report, that the E-Care provider nor RN-A had identified an emergent situation that indicated potential head injury. 3. 9/16/25 at 3:00 a.m., R1’s oxygen level was identified to begin to drop between 86%-89% [oxygen saturation (SpO2)] (92% to 100% is normal range), which was reported to be not his baseline. RN-A then administered an Albuterol nebulizer (inhaled medication) treatment via standing orders at 3:34 a.m.. R1’s oxygen increased to 90% SpO2 for 30 minutes but then reverted back to 86%-88% SpO2. RN-A called E-care back at that time to report change a in condition. R1 reported his headache pain was less painful, and he was no longer vomiting. The E-care provider then ordered a chest x ray STAT (immediately), a urinalysis specimen (UA) with culture, and some blood specimens and additional medication orders. There was no evidence that RN-A disclosed the previous E-Care physician’s call, order changes, R1’s recent fall, or identified the seriousness of the incident and the need to send R1 to the emergency room for in-person evaluation by a physician. 4. 9/16/25 at 5:00 a.m., a nurse aide reported to RN-A that R1 had begun vomiting again. RN-A then called E-Care again requesting a computerized tomography (CT) scan of his head. The E-Care physician told RN-A since R1 was alert and could read questions (R1 had limited hearing so he was asked to read questions rather than hear them asked) used to assess his cognition, they did not believe R1 needed CT scan of his head and only gave order for an X-ray of his. RN-A then entered the orders from the E-Care physician. There was no mention in the report either the E-Care provider, nor RN-A had yet identified the seriousness of R1’s condition. 5. 9/16/25 at approximately 7:30 a.m., when R1’s primary care physician (NP-C) arrived, he was notified of R1’s fall and asked to evaluate R1. PCP directed staff to send R1 to the ER where a head CT was completed and it was noted there were bilateral skull fractures, bilateral brain bleeds, bilateral hemorrhagic contusions (bleeding and bruising) and a subarachnoid hemorrhage(bleeding in the space below one of the thin layers that cover and protect your brain) in the frontal and temporal (side) lobes and a right parietal intraventricular hemorrhage (bleeding in the cerebral ventricular system). Staff noted the call light was not sounding at the time of the fall. The facility identified R1’s care plan had been followed. R1’s 7/23/25, quarterly Minimum Data Set (MDS)		20830				

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20830	Continued from page 4 assessment identified R1 was admitted in December 2022 with diagnoses of dementia, diabetes, anxiety, high blood pressure, insomnia, hearing loss, and anemia. R1's undated, current care plan identified R1 was able to dress himself however, staff were to assist as he allowed. R1 used bilateral grab bars to assist with mobility, positioning, and bed mobility. R1 used a four-wheeled walker and was independent with ambulation. R1 was at risk for falls and staff were to keep his room door open as much as possible, to monitor that his walker was near him, and that he had appropriate footwear on. Staff were to remind him to slow down when walking and check on him every 2 hours. R1's 9/15/25, Fall report identified at 10:23 p.m., a trained medication assistant/nursing assistant (NA)-A had opened the door to R1's room to check on him and found him sitting on floor in front of his recliner. The lights were on, and his walker was over by his closet. The arm rest protectors that were used on his recliner were found on the floor. R1's face was bruised, and he was noted to have swelling around his eyes and his nose was bruised and yellow. His fingers were covered with a small amount of blood, and his thumb nail was broken at the tip. R1 had denied hitting his head but could not explain why he fell. He was alert and orientated to person and time. His neurological assessment was noted to be within normal limits, and his call light was within reach. Interventions identified were to include hourly checks, discontinue arm rest protectors, and provide education to R1 to place his breaks on his walker when it was not in use. The on-call E-Care (telemedicine physician) was notified at 10:45 p.m.. R1's family member was documented as having been notified on 9/16/25 at 7:00 a.m., (8.5 hours later). R1's 9/15/25, Fall Scene Investigation Report (a huddle with staff on duty at time of fall) identified R1 had not utilized his breaks on his walker and did have shoes on at the time of his fall. The fall occurred next to a transfer surface, and the last time R1 was assisted to the restroom was on 9/15/25, at 8:20 p.m.. R1 was found by staff with facial bruising, had swollen eyes and nose, and had bloody fingers. R1's walker was across the room from him by the closet. Question number 4 on the form, noted: "Did the resident hit head or have unwitnessed fall?" The answer was "yes". The form identified if the answer was "yes", staff were to complete vitals (assessments of blood pressure, pulse,		20830				

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20830	Continued from page 5 and respirations), and neurological (neuro) checks (assessment of pupils) per protocol at: A) every 15 minutes x 4, B) every 30 minutes x 2, C) every hour x4, D) every 4 hours x 6, then only vitals 2 x day x 3 days. R1’s 9/15/25 through 9/16/25, neuro checks identified they were completed at:10:38 p.m., within normal limits. (WNL).10:53 p.m., WNL.11:08 p.m., WNL.11:23 p.m.WNL12:23 p.m., WNL, 1 hour later.1:23 a.m., R1 was documented as having a neuro change of a headache (HA).2:23 a.m., identified R1 had HA, nausea and vomiting (N&V).3:23 a.m., identified R1 continued to have a HA, nausea and vomiting (N&V).4:23 a.m., identified R1 continued to have a HA, nausea and vomiting (N&V).The form lacked evidence RN-A had perform 30-minute neuro checks after the 15-minute checks were completed after 11:23 p.m., x 2, per protocol. Interview on 9/22/25 at 1:00 p.m., with registered nurse (RN)-A identified NA-A found R1 on the floor during rounds, at approximately at 10:20 p.m. on 9/15/25. R1 was on the floor by his recliner and his walker was over by his closet. R1 had denied he fell, which was “unusual for him” as R1 had fallen before and “gets mad if we find he has fallen”. He was assessed and at the time, and his neuros and vitals were stable. E-Care (Nurse practitioner (NP)-A) was contacted by phone to report the fall and that R1 had facial bruising. Between 1:00 a.m. and 1:30 a.m., on 9/16/25, RN-A recalled R1 started to complain of a HA, and N&V at that time. She then gave R1 Tylenol and called E-Care and spoke to NP-B (different provider) to report his new symptoms. At that time, NP-B decided to see R1 via telehealth video conferencing. R1 complained of his head hurt and he was shaking at the time. RN-A was then directed by NP-B to give him Zofran. RN-A stated, “I thought that was odd” as R1 was shaking and his blood pressure was elevated. “It was a very busy night, and I was overwhelmed”. RN-A had another resident with an IV that was not working, and another resident on another unit, that she needed to straight catheterize (to assist with urination) for another nurse. RN-A called the hospital resource nurse (RN-H) from the adjacent hospital to come and help her with her duties. NP-B was called again when R1’s oxygen levels dropped. RN-A stated she had “just listened” to NP-B and “did what she said”, as it was “so busy that night”. She had asked NP-B for a CT scan of R1’s head which NP-B declined. NP-B was reported to decline RN-A's recommendation, as R1 had been able to “read the		20830				

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20830	Continued from page 6 questions” RN-A had written out earlier as he was hard of hearing, and his headache had improved. NP-B ordered an X-ray of his facial bones and RN-A took him over to the adjacent hospital's radiology department for the X-ray. RN-A gave report to the oncoming day nurse, the nurse manager (RN-D), and the facility NP (NP-C), who happened to be at the facility early that day (at approximately 7:30 a.m., on 9/16/25). NP-C did assess R1 and had him sent over to the ER immediately. RN-A felt the reason she had not sent R1 over to the ER was because NP-B did not think he need to be seen at the time. RN-A was unaware, she could use her professional judgement to send R1 for medical evaluation. She thought she had to go through E-Care and get a physician’s order to send a resident to the ER. After the fall, the facility did training with all the nurses, and she was made aware a nurse did not need an order to send a resident to the ER. R1 returned from the hospital later that morning and he passed away later that afternoon on 9/16/25. R1’s 9/15/25 at 10:39 p.m., Avel Senior Care (E-Care), Change in Condition written by NP-A, identified RN-A reported R1 was found on floor with marked bruising on face, however, the resident denied hitting his face. It was unknown if R1 hit his head. Neuro assessment identified R1 was alert and orientated x 3 and able to read questions since he was hard of hearing. The NP-A's plan for a non-witnessed fall, was to initiate neuro checks and place him on a fall protocol. Even though he denied head trauma, NP-A ordered staff to monitor his neurological status frequently. NP-A provided the Senior Care Guidance to Monitor for Possible Head Injuries, form that identified signs and symptoms and provided guidance for staff on what to do:Signs and symptoms to watch for included: blacking out/loss of consciousness, headache, dizziness and/or vomiting, new or worsening confusion, trouble recognizing people, unusual sleepiness or difficulty waking up, unusual mood or behavior changes, new or worsening trouble with walking or talking, seizures, bruising behind the ears or around the eyes, and blood or clear drainage from the nose or ear.What to do: identified staff were to monitor the resident for 24-72 hours. It explained: “Early on, there may not be symptoms”. If any of these symptoms develop within 24 hours after a head injury, the resident should be urgently evaluated in the emergency room (ER) if that was consistent with their wishes. If a resident had not wanted to be transferred to the ER for evaluation, they should be urgently evaluated by [E-Care]. There was no indication NP-A had identified or followed the written guidance she gave the facility staff on the common lack of symptoms from		20830				

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20830	Continued from page 7 a head injury as noted above, the facial bruising he already had at the time of the fall, or if she had asked R1 or his family if they desired for R1 to be seen at the ER. R1's 9/16/25 at 1:22 a.m., E-Care provider notification progress note, written by NP-B, identified RN-A called to report R1 was complaining of a headache, nausea, and vomiting. RN-A reported R1 had a fall yesterday. On provider video evaluation, R1 was visualized as awake, responded appropriately, displayed no weakness, followed commands and denied shortness of breath. R1 was anxious and nauseated. NP-B gave new orders for hydroxyzine HCl 25 milligrams (mg) take one tablet by mouth once a day at bedtime for anxiety, and Zofran 4 mg sublingual (SL) every 8 hours one time a day. The hydroxyzine 25 mg order was crossed out and noted (allergy, discontinue (dc)). NP-B also ordered was some blood specimen labs and a UA and urine culture. The order was not electronically signed by NP-B until 9/16/25 at 4:24 a.m. There was no indication in the progress note NP-B recognized R1's deteriorating condition as a sign of need for immediate evaluation in the ER. R1's 9/16/25 at 4:25 a.m., E-Care provider notification note written by NP-B, identified RN-A called to report resident now had hypoxia (lack of oxygen in the blood). RN-A reported R1's oxygen saturation (O2 sats) were at 90%. RN-A had given a nebulizer treatment however, R1's O2 sats remained at 90%. R1 still had nausea and vomiting. R1 was awake and denied pain, chest pain, or abdominal pain. The telehealth exam identified he "was not in any acute distress". Orders were given to place R1 on oxygen at 2 liters (L) via nasal canula and titrate to keep O2 sats above 92%, get a stat (immediate) chest X-ray, albuterol nebs 2.5 mg every 6 hours as needed for shortness of breath, lpratropium 0.5 mg every 6 hours as needed for shortness of breath, facial X-ray 2 views, and follow up with primary provider (NP-C) in the morning. The order was electronically signed later by NP-B 9/16/25 at 5:08 a.m. There was no indication NP-B identified during the call or telehealth assessment, that R1's condition was worsening or that he needed to be sent to the ER to be physically evaluated with a higher level of care. R1's 9/16/25 at 10:14 a.m., provider note by NP-C who identified R1 had been seen today (time unidentified on the note but reported by staff to be approximately 7:30 a.m.) at staff request, to follow up after an E-Care visit during the night due to a fall where the resident		20830				

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20830	Continued from page 8 hit his head. There had been a facial X-ray done at this time. No CT scans were completed, and the resident had not been evaluated in the emergency department during the night. R1, while hard of hearing, was cognitively different than normal during the exam. He was unable to answer questions, and his responses are nonsensical at the time. R1's blood pressure was elevated that morning. Staff reported R1 was complaining of a headache, nausea, and vomiting during the night. NP-C assessed R1's head and face injury, and believed R1 needed a higher level of care and possible admission. NP-C consulted with the ER provider MD-B and gave a brief background of what had happened and recommended that R1 be seen in the emergency department. MD-B agreed, and nursing staff brought R1 over to the ER. Signed electronically by NP-C at 10:23 a.m. R1's 9/16/25 at 8:46 a.m., physician (MD-A)'s emergency department (ER) note identified the clinical impression by the ER physician was R1 suffered a brain bleed with skull fractures. R1's condition was listed as "critical". R1 reported he tripped and fell last night. He had a mild headache but felt it would go away. He had no nausea, no neck pain, no extremity pain and was not on any anticoagulants upon admission. He was alert and oriented and his vital signs were normal. R1 was very hard of hearing but was able to answer questions appropriately. He has periorbital contusions (bruising) bilaterally, with no signs of entrapment. Facial bone computed tomography (CT) was negative. Non-contrast head CT showed multiple significant abnormalities. He had bilateral skull fractures, bilateral subdural hematomas (a pool of blood that can push on the brain), bilateral hemorrhagic contusions (bleeding with bruising) and subarachnoid hemorrhage (bleeding usually from a bulging blood vessel that bursts in the brain (aneurysm) that may lead to permanent brain damage or death if not treated). R1 had left to right subfalcine herniation of 8 millimeters in length (where part of brain tissue moves under a thin membrane that separates the two hemispheres of the brain). [A regional hospital] Neurosurgery was consulted and would accept R1 in a transfer. Keppra was given for seizure prevention, due to subarachnoid hemorrhage. Clinically, R1 declined while at the ER and was not as responsive. After extensive discussion with family, it was unanimously decided not to transfer for aggressive management at that time (related to his deteriorating condition upon his assessment in ER). They would like R1 to be started on hospice and return to the facility.		20830				

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20830	Continued from page 9 Review of the 8/23/23, National Library of Medicine (NIH) article: Subfalcine Herniation, located at: https://www.ncbi.nlm.nih.gov/books/NBK536946/, identified herniation occurred when brain tissue was displaced within in the cranium. Initial presentation can be a headache. It is common to have headache, nausea, vomiting, or altered mental status. Treatment/management depends on the cause, with an attempt to decrease the intracranial (brain) pressure. Medical treatment may be medication or surgical. Surgical treatment could include ICP monitoring, external ventricular drain, craniotomy to remove a hematoma, or decompressive craniectomy. Brain herniation can cause severe clinical disability or death. Brain herniation is potentially reversible with appropriate and timely therapeutic interventions (by a medical provider). The patient and family should be thoroughly counseled about the possible treatment protocols to help in shared decision-making. A timely diagnosis and management will ultimately benefit the patient and improve the clinical outcome. Interview on 9/22/25 at 4:30 p.m., with NA-B identified she was working the night of 9/15/25, when R1 fell. NA-A had come to get her to assist with helping R1 up off the floor after the nurse was done assessing him. R1 was able to walk out to the TV room but he was a “little more shaky” than usual. R1’s face was bruised, and his eyes were swollen, and a cold washcloth was placed over his eyes. In her opinion, R1 should have been taken over to the ER, even though he had denied he fell. When she returned to work the next day around 3:00 p.m., she assisted with repositioning R1 who at that time, was unresponsive. Interview on 9/22/25 at 4:40 p.m., with NA-A identified she had entered R1’s room to check on him on the night of 9/15/25 and found him on the floor with his back against the recliner. R1’s walker was across the room by his closet. His hat was on the floor and the closet door was open slightly. R1’s right thumb was bleeding. Both of his eyes had bruising and looked “baggy”, like he had hit his face. R1’s right hand was more shaky than normal. The nurse assessed R1, and he was assisted up and he was able to walk out to the TV room. RN-A called the E-Care physician, and they said if R1 was “not complaining”, he was “okay”, but she wished he would have been seen in the ER anyway. NA-A was worried about R1 when her evening shift ended. The nurse manager (RN-D) came out to speak to us the following evening on 9/16/25, as it was a “heart-breaking” event and R1 had passed away. She told staff “If we needed,		20830				

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20830	Continued from page 10 we could use the employee [assistance] program”. There was a meeting the next day on 9/17/25, with some of the providers and they had some “good ideas”. The medical director was on the phone for the meeting. The meeting was about preventing future similar events. RN-D was aware NA-A was “having a hard time” with R1’s death. NA-A reported she had asked RN-D, if she could have brought R1 over to the ER herself that night, and even if it was not going to help [R1], she would have felt better. RN-D had told her that “technically” she could take a resident to the ER, but the nurse “should call [E-Care] first”. Interview on 9/22/25 at 3:30 p.m., with licensed nurse (LPN)-B identified if a resident had a fall, the nurse would assess the resident and determine if additional treatment was needed. Depending on the nurse’s assessment, the nurse may send the resident over to the ER for evaluation or may call the E-Care provider, if non-emergent, to obtain an order to send a resident to ER. A nurse did not need an order to send a resident to the ER if the nurse thought (used their professional judgment) they needed to be seen immediately. Further interview on 9/23/25 at 9:10 a.m., with RN-A, identified when E-Care was called, it took a while to get their notes back. She liked to “double check” the provider notes to make sure there were no changes from the oral orders. She noted she could have sent R1 over to the ER when he developed symptoms, but she understood she needed to call E-Care and go through them first. She did feel like R1 should have been sent to the ER, but she felt she needed an order to do that. Staff “had to do as much as possible before sending someone to the ER”. That was “why they had E-Care”. E-Care would assess so “we are not sending residents over unnecessarily”. The facility did do training that we do not need an order to send someone to the ER we can just send if we feel it is needed. She was offered to speak to someone if she needed as she reported she felt “so bad about the outcome” of this resident. Interview on 9/23/25 at 9:53 a.m., with medical director (MD-B) identified she had been notified of the incident. She revealed there were “many parts” contributing to the incident. MD-B was concerned how the providers (NP-A and NP-B) handled the situation and had referred one for peer review. She identified she “supported” a lot of long-term care facilities and had done education with nurses in the past, that they do not need a physician order to send someone to the		20830				

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20830	Continued from page 11 emergency department. “Unfortunately, there is a belief out there that they need an order”, and they have a hard time sending someone to the ER without one. She would expect anytime there was something “clearly alarming”, the nurse would send a resident to the ER for an evaluation. They do not need an order for that. She had not spoken to the nurse on duty that night (RN-A) but “felt bad for her” as she felt RN-A likely thought she was doing the right thing by reaching out to E-Care for direction. E-Care did “lay eyes” on the resident. She had concerns about the decisions by E-Care that were made. MD-B felt the outcome would not have changed for R1 due to his significant fractures and the family choosing not to pursue aggressive treatment (after discovery of the fractures in the ER) however, she would have expected that conversation to have happened “sooner than it did”. She had completed a thorough review of R1’s medical record and provider notes. The following day she participated in a meeting with the facility and discussed things that lead up to the event and what the facility could do to prevent events like this from happening again. Interview on 9/23/25 at 11:03 a.m., with director of nursing (DON) identified she had visited with RN-A and educated her that she could send a resident over to the ER anytime she had concerns. RN-A’s “intuition” was that “something was wrong”, and she hoped now she would feel more empowered to follow her intuition in the future. She would expect a nurse to act on their assessments and critical thinking and send someone to the ER for evaluation if the nurse felt it was needed. She revealed it maybe hard for nurses to “override [decisions by] a provider” and send someone to the ER if that provider did not agree, but at times that might need to be done since the nurse’s know the residents better, or if “something was not right”. She confirmed R1 should have been seen in the ER immediately but especially after he started to develop symptoms of headache, nausea and vomiting. All licensed nurses were retrained starting on 9/18/25, on E-Care and Emergency room services, ARCC (Ask a question, make a request, voice a concern, use chain of command) and how to use ARCC. Interview on 9/23/25 at 3:53 p.m., with RN-G who was also the facility education nurse, identified she had been the nurse on-call the night of 9/15/25 into 9/16/25. She had not been called by RN-A to come in and assist her “with anything”. RN-A had not reached out to her to consult about R1’s fall or any concerns she may have had about him developing symptoms. The facility		20830				

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20830	Continued from page 12 had an internal departmental meeting anytime there was a fall with a major injury or if a resident was having multiple falls. These meeting were to discuss the fall or falls and determine a root cause. Training was provided to all the nurses following R1’s event. We encourage our nurses to collaborate with each other all the time and encourage collaboration with the providers. Interview on 9/23/25 at 4:37 p.m., with licensed practical nurse (LPN)-A, identified he worked the night of R1’s fall on a different unit. RN-A had come to the unit he was working on at around 3:00 a.m. or 4:00 a.m. to obtain Zofran from the emergency medication kit. RN-A had not asked him to assess R1 however, she had told him that R1 was having nausea and vomiting after having a fall. LPN-A revealed he had advised RN-A to send R1 to the ER because “anyone having a fall and developing symptoms like that should be seen”. Interview on 9/23/25 at 4:44 p.m., with RN-H (the resource nurse from the attached hospital) identified the facility had called and requested the resource nurse to come and restart an IV that was not working. RN-H reported no facility staff mentioned any other residents. She was just asked to start the IV on another resident. After that, she returned to the hospital. Later interview on 9/24/25 at 9:08 a.m., with the DON identified that the nurse managers all take call. Charge nurses (like RN-A) were able to call for any questions they may have. The facility had a system called Volt (an internal communication system). The nurses could communicate via text messaging or calling different staff through the Volt system. She was unaware RN-A thought she needed a physician order to send a resident to the ER for an evaluation until she had spoken with her. She was unaware that other staff on duty that night (LPN-A) had voiced concerns of R1 to RN-A and had advised they had felt R1 should have been sent to the ER for an evaluation. She also had not been made aware that NA-A had asked a nurse supervisor if they could have advocated for R1 and just have taken him over to the emergency room. A call was placed on 9/24/25 at 11:09 a.m., with a message left for MD-A but a call was not returned.		20830				

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20830	Continued from page 13 The IJ that began on 9/15/25 was determined to be past noncompliance when it could be verified the facility took steps to correct the deficient practice prior to the survey by reviewing all fall related policies as noted and educating all licensed nursing staff to those policies. The May 2025, Fall Prevention and Management policy identified a fall risk assessment would be completed for each resident upon admission, re-admission, and quarterly. Residents determined to be at risk will have fall interventions incorporated into their care plan. After, a fall a post fall assessment would be completed to determine the root cause to prevent further falls. The nurse was to notify the physician and family at time of fall. The October 2024, LTC Falls and Accidents policy identified upon admission, re-admission, and quarterly the facility would assess fall risk, elopement risk, and other risk within the facility. The facility would implement interventions for any identified risk on the care plan. For a fall, the nurse was to immediately assess the resident for any injury. A head injury must include vital signs and neurological assessment at least every 4 hours x 4 and then daily for 72 hours. A fall must be investigated for root cause and individualize the residents care plan with interventions. The November 2024, Provider/Medical Services LTC policy identified for a resident that had a change in condition, the medical provider was to be contacted on the condition. For any life threatening or emergency, the resident was to be sent over to the ER for an evaluation. The facility had access to Avel (E-Care) services a telehealth-based system, which offered a virtual face-to-face visit. This system provided access to residents and providers to provide a medical evaluation, treatment and referral as appropriate. This system could be utilized for a change in condition in a non-emergent situation and accessed 24 hours a day with the resident's primary provider (PCP) being notified of the use of Avel virtual services and the resident's condition. The December 2024, Chain of Command and Administrative Call policy identified staff who have identified a problem situation would collaborate with their peers to determine the urgency of the problem. The responsible		20830				

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20830	Continued from page 14 provider would be contacted for clarification. If the problem remained unresolved, the staff were to seek guidance of the LTC charge nurse. The charge nurse would contact the responsible provider. If the concern continues to be unresolved and there was an immediate risk to the resident care and safety, the charge nurse was to contact the LTC leader on-call if on a weekend, or the director of nursing on a weekday. The findings would be reviewed and if needed, the LTC leader on call or administrator would call for further clarification and discussion. If the issue remains unresolved, the administrator would be contacted and they would notify the chief medical officer, if needed, for assistance. The undated, E-Care and Emergency Room Services policy identified for a resident experiencing an injury or illness, the nurse was to assess and determine the best course of action for the resident. Staff were to address E-Care services with the resident and family. If staff were unable to contact family and/or resident was unable to make their needs known, staff had the right to send the resident to the emergency room. The nurse may contact E-Care for all non-emergent needs to confer with an on-call provider. The nurse had a right to utilize the emergency department based on their clinical judgement and assessment. A physician's order was not required to send a resident into the emergency room for evaluation. If a nurse was in doubt about whether to pursue further medical care, they were to collaborate with another nurse. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review policies and procedures, train staff, and implement measures to ensure appropriate action, supervision and analysis of falls occurs. The DON or designee should educate staff and conduct measurable audits of falls with injury to ensure appropriate and timely medical intervention was completed, audit fall to ensure analysis of the root cause is completed, and ensure identified interventions are in place to prevent falls. The DON or designee should ensure the results of those audits are taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.		20830				