DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 7, 2026

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

RE: CCN: 245228
Cycle Start Date: March 24, 2026

Dear Administrator:

On April 1, 2026, we notified you a remedy was imposed. On April 29, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 21, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 16, 2026, be discontinued as of April 21, 2026. (42 CFR 488.417 (b))

In our letter of April 1, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 16, 2026. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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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May 7, 2026

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

Re: Reinspection Results
Event ID: 1F16F2-H1

Dear Administrator:

On April 29, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 24, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
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April 1, 2026

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

RE: CCN: 245228
Cycle Start Date: March 24, 2026

Dear Administrator:

On March 26, 2026, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 16, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 16, 2026. They will also notify

the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 16, 2026.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by April 16, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, [Facility Name()] will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 16, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 24, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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.

Feel free to contact me if you have questions.

Sincerely,

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

An equal opportunity employer.

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April 1, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1F16F2-H1

Dear Administrator:

The above facility survey was completed on March 24, 2026 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
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 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Morningside Heights Care Center	**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 3/23/26 to 3/24/26, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed: H52283580C (2714360); with noncompliance cited at F689. H52285120C (2731597) H52288980C (2807648) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/09/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review,	F0689	The facility developed a One to One Observation policy defining One to One Observation, including documentation and care plan requirements. Education will be completed by 4/21/2026 to all licensed staff that includes: review of the one-to-one observation policy, expectation on escalation communication, and documentation. The facility developed “Increased Supervision for Residents” Education and will be completed by 04/21/52026 to licensed nursing staff to provide clear guidance on appropriate use, implementation, and documentation of increased supervision for residents to ensure safety while maintaining accurate clinical documentation. To verify staff understand the definition and expectations of One-to-One Observation audits will be	04/21/2026

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

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 03/24/2026

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

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F0689 SS = G	Continued from page 1 the facility failed to ensure adequate supervision was provided to prevent falls for 1 of 3 residents (R2) reviewed for falls. R2 needed increased monitoring for safety due to her fall risk with one-to-one (1:1) supervision which was not provided when the nursing assistant (NA) left R2 alone to go wash their hands. R2 then fell causing harm when R2 obtained a left olecranon (elbow) fracture which needed surgery. Findings include: R2's progress note, dated 1/2/26, identified R2 admitted to the nursing home from the hospital. R2 was an assistance of two staff with an EZ Stand for transfers and was non-weight bearing (NWB) to her right upper extremity with a sling on at all times. R2 was recorded as not verbally responding and having poor memory due to dementia. R2's Fall Risk Assessment, dated 1/2/26, identified R2 had sustained a fall within the last three months, had altered mental status, impaired mobility, and consumed at-risk medications. The assessment scored R2 as, "5: Higher fall risk precautions," and directed interventions which included non-skid footwear and PT/OT. R2's 5-Day Minimum Data Set (MDS), dated 1/8/26, identified R2 had severe cognitive impairment and had sustained falls prior to admission with a fracture. R2's corresponding Falls Care Area Assessment (CAA), dated 1/10/26, identified R2 had advanced dementia with severe aphasia (communication disorder) and was rarely understood. The CAA recorded R2 had sustained a fall prior to her admission with fracture obtained (right elbow) and listed her being not behavioral but "just busy" which placed her at continued high risk for falls. The CAA identified R2's assessed risks as falls, pain, injury, and decline. R2's progress note, dated 1/11/26, identified R2 had a fall on 1/10/26 at 9:12 a.m. with dictation, "... [R2] had been one on one with staff in the evening due to restlessness for her safety. Staff were with [R2] in the open area dining room giving her a snack and getting her settled after her HS [bedtime] medications had been given. Staff were needed to help a two-assist resident, so were called away. It is estimated that about two minutes lapsed from the time they had to leave her to the time this writer came around the	F0689	Continued from page 1 conducted via verbal Knowledge check. Sample size 5 staff per week, with 100% x3 weeks. Compliance and effectiveness of corrective actions will be monitored through the QAPI program. The facility has completed a review of R2's comprehensive assessment and care plan to ensure all assessed needs are accurately documented, reflected in the care plan, and aligned with the resident's current level of care. Nursing leadership has verified that the care plan is current and that staff are following the care plan interventions as written. In addition, the facility will conduct a review of all residents by 4/21/2026 considered a higher fall risk and requiring a similar level of care to ensure that assessments are accurate, care plans appropriately reflect assessed needs, and staff are following the individualized care plans. Any discrepancies identified were addressed immediately through care plan updates and staff education to ensure ongoing compliance. Nursing leadership will conduct audits of residents who are identified as higher risk for falls to ensure assessments are current, care plans accurately reflect assessed needs, and staff are consistently following all documented fall prevention interventions. Sample size: 5 residents monthly with 100% compliance x3 months. Compliance and effectiveness of corrective actions will be monitored through the QAPI program.	

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 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Morningside Heights Care Center	300 SOUTH BRUCE STREET , MARSHALL, Minnesota, 56258

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F0689 SS = G	Continued from page 2 corner in the dining room area where she was found in the middle of the room on the floor with her wheelchair behind her." The fall resulted in two lacerations above her left eye, a small bleed on her left elbow, a skin tear, and a hematoma. The provider was updated and ordered R2 to be seen in the emergency department (ED). Registered nurse (RN)-D authored the note. R2's FSI - Fall Scene Investigation Report, dated 1/10/26, identified a section to record the fall details. This identified a hand-drawn photo of how R2 was found on the floor with injuries listed as "head laceration" and "left elbow skin tear." Just prior to the fall, R2 was recorded as sitting by kitchen self-propelling in the wheelchair facing the staff. The staff was called away for a two person assist, then staff came back and gave her a snack, then left again to help another resident when R2 was then found on the floor. R2 hit her head due to the unwitnessed fall. The report included a section to be completed by the primary NA working with R2 who recorded, "The patient has been one on one with the writer, offered snacks and drinks and has been moving with the wheelchair all around the unit all under watch." The NA then pushed R2 next to a patient room where the other NA needed help. The NA then left R2 to assist the other NA, returned and spoke with R2, and then left again to dispose of the trash. NA-C authored this section of the note. The report continued and listed a section labeled, "Root Cause of This Fall," which identified a checkmark placed next to R2's medical status and mental status with handwritten, "Severe Dementia." The section asked, "What appears to be the root cause of the fall[?]," which was answered in writing by RN-D as, "She was not one on one - self-propelled [sic] herself and attempted to get up and fell." A new intervention was written that if staff have to leave R2 unattended, they should let the nurse know so options can be assessed. R2's Fall Follow Up, dated 1/10/26, identified an initial evaluation of the fall and repeated several items from RN-D's progress note along with R2 being sent to the hospital ED and diagnosed with a displaced olecranon fracture. The report identified registered nurse manager (RN)-B was notified of the fall. A section labeled, "Fall Severity," identified R2 as having sustained, "Major Injury." A section labeled, "Post Fall Investigation," identified R2 had sustained falls in the last week or more than three times within the past 30-day period with notes, "[R2] admitted to our facility post status right hip fx [fracture] and right arm fx." The intervention placed for this fall on	F0689		

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F0689 SS = G	Continued from page 3 1/10/26 was if staff were called away to assist others and R2 could not be placed next to a table to prevent her leaning forward, to let a nurse know so options can be explored. A subsequent Follow Up, dated 1/11/26, identified the fall from 1/10/26 but this time included a section labeled, "Post Fall Education Additional Information," which directed an intervention was communicated with staff that if they need to leave R2 unattended when she is not settled that they need to tell the nurse so something can be done to get someone by her. A corresponding Threshold Investigation Worksheet, undated, identified R2's fall on 1/10/26 was reviewed by the nursing team. R2's progress note (dated 1/11/26 by RN-D) was reposted to it as background information with a section below which posed arrows going down for staff to ask, "WHY?" after each item identified. This recorded only two items which were, "Why did [R2] fall?" > "She was trying to get up to find someone." The report identified two strengths from the situation, in which staff identified R2 needed to be a 1:1 due to anxiousness and attempted to see if she had unmet needs. The one opportunity they determined was, "Better communication surrounding when staff need to leave a resident due to caring for another resident." R2's Emergency Department (ED) Discharge Plan, dated 1/10/26, identified R2 was seen in an ED for a fall at the nursing home which left an abrasion of her elbow, forehead laceration, and a closed olecranon fracture. R2 presented with advanced dementia and was found on the floor in front of her chair with exact details of the fall being unknown. R2 was recorded as non-verbal at baseline but said, "Ow," with movement in the ED so an x-ray was ordered which identified a left elbow olecranon fracture. R2 was placed in a sling, and an orthopedic follow-up was recommended. R2 was discharged back to the nursing home. R2's care plan, dated 1/30/26, identified R2 was at risk for falls or injury due to a history of prior falls and poor balance. The plan listed interventions recorded as “Safety Measures," being last revised on 1/11/26. These included notifying the nurse if the NA has to leave her alone, offering food or toileting if restless, and using "busy boards" or wildlife shows to occupy her time. The care plan lacked any current or historical recorded intervention for 1:1 supervision despite the progress notes saying one was needed.	F0689		

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F0689 SS = G	Continued from page 4 R2's progress note, dated 2/12/26, identified R2 went to an orthopedic appointment with her family member present. The x-rays showed stable alignment of the left elbow and family agreed to proceed with surgery. R2 was ordered to continue with the Exos brace (splint used for fractures in hand or elbow) and orthopedics would schedule an open-reduction internal fixation (ORIF) left olecranon fracture. R2's progress note, dated 2/25/26, identified R2 was sent to same-day surgery for the procedure and returned NWB on her left elbow and with new pain medication prescriptions. During observation on 3/23/26 at 1:22 p.m., R2 was seated in a high-back wheelchair in the commons area of the unit watching television. R2 appeared comfortable and had a black-colored sling on her left arm. R2 smiled when conversed with, however, did not respond to many questions or mumbled a response which was undiscernible. R2 was asked if she had fallen at all in the past months which she did answer, "No," and smiled. When interviewed on 3/23/26 at 1:24 p.m., NA-A stated they were working with R2 and described her as needing help with most cares including eating. NA-A stated R2 used the sling on her left arm since she came to the unit from the TCU several weeks prior. NA-A stated they knew R2 had fallen in the TCU but was not sure whether she had gotten injured or not with it. NA-A stated R2 had not sustained anymore falls since she moved to the new unit and R2 was not "as active" on this unit as she had been on the TCU. NA-A stated staff tried to keep a close eye on her and kept her in the commons area, often including at nighttime but was not on a formal 1:1 anymore. NA-A stated if a resident were on 1:1 and they had to leave them, they would wait to find a nurse or someone else to sit with them first. When interviewed on 3/24/26 at 7:24 a.m., NA-B recalled working on 1/10/26 when R2 fell. NA-C was sitting with R2 in the commons area when NA-B needed help in another room, so NA-C placed R2 while seated in the wheelchair outside the door and told R2 to "be patient" while they helped. They finished the care and NA-C then left the room while NA-B stayed in the room to clean up. NA-B stated NA-C had then left R2 unattended in the dining room area while leaving to wash their hands and throw trash away. RN-D came into the dining room and found R2	F0689		

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 03/24/2026

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F0689 SS = G	Continued from page 5 on the floor. NA-B stated R2 did not have any injuries or issues with her left arm or elbow prior to the fall on 1/10/26. NA-B recalled R2 as being 1:1 with staff before she fell that evening due to her cognition. NA-B stated if someone was a 1:1, then staff needed to remain with them and have constant supervision on them and if R2 was in the dining room and someone left to go to soiled utility it would have been out of sight. NA-B stated they were unsure why NA-C did not just wash their hands in the kitchen sink which was in the same room as R2. Following the fall, NA-B stated themselves, NA-C, and RN-D then decided to make sure the RN would be asked to sit with R2 if staff needed to leave her again instead of just leaving her unsupervised. NA-B stated nobody from management had told them that, it was just them working when it happened who decided that. NA-B reiterated a 1:1 means someone needs to always stay with the person and had that been done R2's fall was likely preventable. When interviewed on 3/24/26 at 8:03 a.m., NA-C stated they recalled R2 as being a fall risk and were assigned to R2 when she fell on 1/10/26. NA-C stated they were called to help with another patient by NA-B, so they moved R2 next to the door of that room and told R2 to stay there and they had come back. NA-C then went inside the other resident room and closed the door. When they opened it upon completion of care, R2 had wheeled herself back into the dining room. NA-C again told R2 to stay there and left to go dispose of trash and wash their hands down the hall while out of sight of R2. NA-C was washing their hands when suddenly RN-D called for help and R2 was on the floor. NA-C recalled R2 being very confused that night and stated they did not call for help prior to leaving R2 as they told R2 to wait there and would be right back. NA-C recalled R2 being a 1:1 as she had worked with her prior and she was a 1:1 then adding, "We knew that [1:1]." The RN had told them R2 was a 1:1 that night, too, adding aloud, "This patient is a 1:1." NA-C stated a 1:1 meant someone should stay with them at all times but again acknowledged leaving the patient quick to wash their hands when she fell. NA-C stated the group involved with the fall then discussed it and talked about how to prevent it again but nobody had discussed or provided re-education on a 1:1 and it's expectations since then though adding aloud, "I can't recall that they talked about that." An interview was attempted with RN-D during the abbreviated survey; however, they were on leave and unavailable for interview per the campus	F0689		

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F0689 SS = G	Continued from page 6 administration. On 3/24/26 at 10:05 a.m., a group interview was held with registered nurse unit manager (RN)-B and the director of nursing (DON). RN-B explained someone's fall risk was assessed upon admission and then care plan interventions would be placed from that assessment. These interventions were "kinda generalized" until they learned more about the resident then more specific interventions would be identified. RN-B stated R2 was admitted with fractures from a fall in her right arm, and the new left elbow fracture happened from the fall on 1/10/26, with R2 possibly being on 1:1 that night due to being more "busy" and moving around more. It was not care planned but rather had just been "nurse driven" as an intervention. DON stated they felt there were "different avenues" someone could use if on 1:1 including just frequent checks versus constant supervision adding staff were "trying our best" to keep her in the line of sight they felt. DON stated there was not a specific policy or procedure for 1:1 to help define the exact expectations with it, which they had just talked with the administrator and identified as "a takeaway" from this situation. DON stated they felt the documentation listed in the progress notes and FSI meant to watch R2 closely but did not necessarily mean keeping constant eyesight of her. DON stated if R2 had been 1:1 like they'd expect for a suicide-risk (i.e., direct, constant supervision) then R2's fall was likely preventable but if it was just frequent checks like they felt this situation to be, then there was a chance a fall could still happen despite. Following the fall, some general education on teamwork had been sent to all staff members and RN-B stated they believed they discussed 1:1 expectation at a NA meeting since the fall and would provide that documentation. At 10:38 a.m., RN-B reviewed the agenda from their unit meeting (dated 1/29/26) which identified a discussion labeled, "1:1 activities / what is 1:1," and, "Prevent fractures from self-transfers," with an attached sign-in sheet listing employee names and a "X" if attended. This listing had a total of 91 active employees (as of 1/29/26) but 51 of them did not have an "X" to demonstrate re-education on the topics. RN-B stated they recalled having discussion on 1:1 at the meeting and using teamwork to ensure supervision is provided when needed. RN-B acknowledged the multiple names on the listing without re-education and stated they were still trying to get some people caught up on it and working on a different system to get better attendance at the meetings. RN-B verified the nurses of the unit were not included in the re-education, either, since it was specific to NA staff members.	F0689		

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F0689 SS = G	Continued from page 7 When interviewed on 3/26/26 at 11:06 a.m., RN-C stated they were currently assigned to R2 and were aware R2 had fallen on the TCU prior and obtained an elbow fracture from it. RN-C stated if they directed a 1:1 for a patient then they expected the NA to have eyesight of them at all times. RN-C there had been no discussion of 1:1's or their expectation to the nurses on it recently to their recall adding, "Not that I'm aware of." On 3/24/26 at 12:04 p.m., the DON and administrator were interviewed. DON stated they did not feel the language in the FSI, and progress notes meant a direct 1:1 needed prior to R2's fall but rather the documentation supported that was maybe a new intervention to do post-fall. DON stated the NA staff may have identified R2 was restless and needed more supervision on 1/10/26 and felt they could handle it themselves. DON reiterated they did not feel the language in the chart reflected a 1:1 was needed prior to the fall. The facility LTC (Long-term Care) Falls and Accidents policy, dated 10/2024, identified supervision defined as a determination based on the individual resident's assessed needs and identified hazards in the environment. This added, "Adequate supervision may vary from resident to resident and from time to time for the same resident." The policy directed staff would be educated on preventing residents' falls and have access to the care plans for each resident. The resident would also be assessed for fall risk and based upon that, have individualized interventions in place to reduce the risk.	F0689		

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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 3/23/26 to 3/24/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the 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		04/09/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H52283580C (2714360); order issued at 0830. H52285120C (2731597) H52288980C (2807648) MDH 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 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 4658.0400 and 4658.0405. A nursing home resident must	20830	The facility developed a One to One Observation policy defining One to One Observation, including documentation and care plan requirements. Education will be completed by 4/21/2026 to all licensed staff that includes: review of the one-to-one observation policy, expectation on escalation communication, and documentation. The facility developed “Increased Supervision for	04/21/2026

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20830	Continued from page 2 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 observation, interview, and document review, the facility failed to ensure adequate supervision was provided to prevent falls for 1 of 3 residents (R2) reviewed for falls. R2 needed increased monitoring for safety due to her fall risk with one-to-one (1:1) supervision which was not provided when the nursing assistant (NA) left R2 alone to go wash their hands. R2 then fell causing harm when R2 obtained a left olecranon (elbow) fracture which needed surgery. Findings include: R2's progress note, dated 1/2/26, identified R2 admitted to the nursing home from the hospital. R2 was an assistance of two staff with an EZ Stand for transfers and was non-weight bearing (NWB) to her right upper extremity with a sling on at all times. R2 was recorded as not verbally responding and having poor memory due to dementia. R2's Fall Risk Assessment, dated 1/2/26, identified R2 had sustained a fall within the last three months, had altered mental status, impaired mobility, and consumed at-risk medications. The assessment scored R2 as, "5: Higher fall risk precautions," and directed interventions which included non-skid footwear and PT/OT. R2's 5-Day Minimum Data Set (MDS), dated 1/8/26, identified R2 had severe cognitive impairment and had sustained falls prior to admission with a fracture. R2's corresponding Falls Care Area Assessment (CAA), dated 1/10/26, identified R2 had advanced dementia with severe aphasia (communication disorder) and was rarely understood. The CAA recorded R2 had sustained a fall prior to her admission with fracture obtained (right elbow) and listed her being not behavioral but "just busy" which placed her at continued high risk for falls. The CAA identified R2's assessed risks as falls, pain, injury, and decline. R2's progress note, dated 1/11/26, identified R2 had a fall on 1/10/26 at 9:12 a.m. with dictation, "... [R2]	20830	Continued from page 2 Residents" Education and will be completed by 04/21/52026 to licensed nursing staff to provide clear guidance on appropriate use, implementation, and documentation of increased supervision for residents to ensure safety while maintaining accurate clinical documentation. To Verify staff understand the definition and expectations of One-to-One Observation audits will be conducted via verbal Knowledge check. Sample size 5 staff per week, with 100% x3 weeks. Compliance and effective of corrective actions will be monitored through the QAPI program.	

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20830	Continued from page 3 had been one on one with staff in the evening due to restlessness for her safety. Staff were with [R2] in the open area dining room giving her a snack and getting her settled after her HS [bedtime] medications had been given. Staff were needed to help a two-assist resident, so were called away. It is estimated that about two minutes lapsed from the time they had to leave her to the time this writer came around the corner in the dining room area where she was found in the middle of the room on the floor with her wheelchair behind her." The fall resulted in two lacerations above her left eye, a small bleed on her left elbow, a skin tear, and a hematoma. The provider was updated and ordered R2 to be seen in the emergency department (ED). Registered nurse (RN)-D authored the note. R2's FSI - Fall Scene Investigation Report, dated 1/10/26, identified a section to record the fall details. This identified a hand-drawn photo of how R2 was found on the floor with injuries listed as "head laceration" and "left elbow skin tear." Just prior to the fall, R2 was recorded as sitting by kitchen self-propelling in the wheelchair facing the staff. The staff was called away for a two person assist, then staff came back and gave her a snack, then left again to help another resident when R2 was then found on the floor. R2 hit her head due to the unwitnessed fall. The report included a section to be completed by the primary NA working with R2 who recorded, "The patient has been one on one with the writer, offered snacks and drinks and has been moving with the wheelchair all around the unit all under watch." The NA then pushed R2 next to a patient room where the other NA needed help. The NA then left R2 to assist the other NA, returned and spoke with R2, and then left again to dispose of the trash. NA-C authored this section of the note. The report continued and listed a section labeled, "Root Cause of This Fall," which identified a checkmark placed next to R2's medical status and mental status with handwritten, "Severe Dementia." The section asked, "What appears to be the root cause of the fall[?]," which was answered in writing by RN-D as, "She was not one on one - self-propelled [sic] herself and attempted to get up and fell." A new intervention was written that if staff have to leave R2 unattended, they should let the nurse know so options can be assessed. R2's Fall Follow Up, dated 1/10/26, identified an initial evaluation of the fall and repeated several items from RN-D's progress note along with R2 being sent to the hospital ED and diagnosed with a displaced olecranon fracture. The report identified registered	20830		

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20830	Continued from page 4 nurse manager (RN)-B was notified of the fall. A section labeled, "Fall Severity," identified R2 as having sustained, "Major Injury." A section labeled, "Post Fall Investigation," identified R2 had sustained falls in the last week or more than three times within the past 30-day period with notes, "[R2] admitted to our facility post status right hip fx [fracture] and right arm fx." The intervention placed for this fall on 1/10/26 was if staff were called away to assist others and R2 could not be placed next to a table to prevent her leaning forward, to let a nurse know so options can be explored. A subsequent Follow Up, dated 1/11/26, identified the fall from 1/10/26 but this time included a section labeled, "Post Fall Education Additional Information," which directed an intervention was communicated with staff that if they need to leave R2 unattended when she is not settled that they need to tell the nurse so something can be done to get someone by her. A corresponding Threshold Investigation Worksheet, undated, identified R2's fall on 1/10/26 was reviewed by the nursing team. R2's progress note (dated 1/11/26 by RN-D) was reposted to it as background information with a section below which posed arrows going down for staff to ask, "WHY?" after each item identified. This recorded only two items which were, "Why did [R2] fall?" > "She was trying to get up to find someone." The report identified two strengths from the situation, in which staff identified R2 needed to be a 1:1 due to anxiousness and attempted to see if she had unmet needs. The one opportunity they determined was, "Better communication surrounding when staff need to leave a resident due to caring for another resident." R2's Emergency Department (ED) Discharge Plan, dated 1/10/26, identified R2 was seen in an ED for a fall at the nursing home which left an abrasion of her elbow, forehead laceration, and a closed olecranon fracture. R2 presented with advanced dementia and was found on the floor in front of her chair with exact details of the fall being unknown. R2 was recorded as non-verbal at baseline but said, "Ow," with movement in the ED so an x-ray was ordered which identified a left elbow olecranon fracture. R2 was placed in a sling, and an orthopedic follow-up was recommended. R2 was discharged back to the nursing home. R2's care plan, dated 1/30/26, identified R2 was at risk for falls or injury due to a history of prior falls and poor balance. The plan listed interventions	20830		

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20830	Continued from page 5 recorded as “Safety Measures," being last revised on 1/11/26. These included notifying the nurse if the NA has to leave her alone, offering food or toileting if restless, and using "busy boards" or wildlife shows to occupy her time. The care plan lacked any current or historical recorded intervention for 1:1 supervision despite the progress notes saying one was needed. R2's progress note, dated 2/12/26, identified R2 went to an orthopedic appointment with her family member present. The x-rays showed stable alignment of the left elbow and family agreed to proceed with surgery. R2 was ordered to continue with the Exos brace (splint used for fractures in hand or elbow) and orthopedics would schedule an open-reduction internal fixation (ORIF) left olecranon fracture. R2's progress note, dated 2/25/26, identified R2 was sent to same-day surgery for the procedure and returned NWB on her left elbow and with new pain medication prescriptions. During observation on 3/23/26 at 1:22 p.m., R2 was seated in a high-back wheelchair in the commons area of the unit watching television. R2 appeared comfortable and had a black-colored sling on her left arm. R2 smiled when conversed with, however, did not respond to many questions or mumbled a response which was undiscernible. R2 was asked if she had fallen at all in the past months which she did answer, "No," and smiled. When interviewed on 3/23/26 at 1:24 p.m., NA-A stated they were working with R2 and described her as needing help with most cares including eating. NA-A stated R2 used the sling on her left arm since she came to the unit from the TCU several weeks prior. NA-A stated they knew R2 had fallen in the TCU but was not sure whether she had gotten injured or not with it. NA-A stated R2 had not sustained anymore falls since she moved to the new unit and R2 was not "as active" on this unit as she had been on the TCU. NA-A stated staff tried to keep a close eye on her and kept her in the commons area, often including at nighttime but was not on a formal 1:1 anymore. NA-A stated if a resident were on 1:1 and they had to leave them, they would wait to find a nurse or someone else to sit with them first. When interviewed on 3/24/26 at 7:24 a.m., NA-B recalled working on 1/10/26 when R2 fell. NA-C was sitting with	20830		

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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
20830	Continued from page 6 R2 in the commons area when NA-B needed help in another room, so NA-C placed R2 while seated in the wheelchair outside the door and told R2 to "be patient" while they helped. They finished the care and NA-C then left the room while NA-B stayed in the room to clean up. NA-B stated NA-C had then left R2 unattended in the dining room area while leaving to wash their hands and throw trash away. RN-D came into the dining room and found R2 on the floor. NA-B stated R2 did not have any injuries or issues with her left arm or elbow prior to the fall on 1/10/26. NA-B recalled R2 as being 1:1 with staff before she fell that evening due to her cognition. NA-B stated if someone was a 1:1, then staff needed to remain with them and have constant supervision on them and if R2 was in the dining room and someone left to go to soiled utility it would have been out of sight. NA-B stated they were unsure why NA-C did not just wash their hands in the kitchen sink which was in the same room as R2. Following the fall, NA-B stated themselves, NA-C, and RN-D then decided to make sure the RN would be asked to sit with R2 if staff needed to leave her again instead of just leaving her unsupervised. NA-B stated nobody from management had told them that, it was just them working when it happened who decided that. NA-B reiterated a 1:1 means someone needs to always stay with the person and had that been done R2's fall was likely preventable. When interviewed on 3/24/26 at 8:03 a.m., NA-C stated they recalled R2 as being a fall risk and were assigned to R2 when she fell on 1/10/26. NA-C stated they were called to help with another patient by NA-B, so they moved R2 next to the door of that room and told R2 to stay there and they had come back. NA-C then went inside the other resident room and closed the door. When they opened it upon completion of care, R2 had wheeled herself back into the dining room. NA-C again told R2 to stay there and left to go dispose of trash and wash their hands down the hall while out of sight of R2. NA-C was washing their hands when suddenly RN-D called for help and R2 was on the floor. NA-C recalled R2 being very confused that night and stated they did not call for help prior to leaving R2 as they told R2 to wait there and would be right back. NA-C recalled R2 being a 1:1 as she had worked with her prior and she was a 1:1 then adding, "We knew that [1:1]." The RN had told them R2 was a 1:1 that night, too, adding aloud, "This patient is a 1:1." NA-C stated a 1:1 meant someone should stay with them at all times but again acknowledged leaving the patient quick to wash their hands when she fell. NA-C stated the group involved with the fall then discussed it and talked about how to prevent it again but nobody had discussed or provided	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/24/2026**

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20830	Continued from page 7 re-education on a 1:1 and it's expectations since then though adding aloud, "I can't recall that they talked about that." An interview was attempted with RN-D during the abbreviated survey; however, they were on leave and unavailable for interview per the campus administration. On 3/24/26 at 10:05 a.m., a group interview was held with registered nurse unit manager (RN)-B and the director of nursing (DON). RN-B explained someone's fall risk was assessed upon admission and then care plan interventions would be placed from that assessment. These interventions were "kinda generalized" until they learned more about the resident then more specific interventions would be identified. RN-B stated R2 was admitted with fractures from a fall in her right arm, and the new left elbow fracture happened from the fall on 1/10/26, with R2 possibly being on 1:1 that night due to being more "busy" and moving around more. It was not care planned but rather had just been "nurse driven" as an intervention. DON stated they felt there were "different avenues" someone could use if on 1:1 including just frequent checks versus constant supervision adding staff were "trying our best" to keep her in the line of sight they felt. DON stated there was not a specific policy or procedure for 1:1 to help define the exact expectations with it, which they had just talked with the administrator and identified as "a takeaway" from this situation. DON stated they felt the documentation listed in the progress notes and FSI meant to watch R2 closely but did not necessarily mean keeping constant eyesight of her. DON stated if R2 had been 1:1 like they'd expect for a suicide-risk (i.e., direct, constant supervision) then R2's fall was likely preventable but if it was just frequent checks like they felt this situation to be, then there was a chance a fall could still happen despite. Following the fall, some general education on teamwork had been sent to all staff members and RN-B stated they believed they discussed 1:1 expectation at a NA meeting since the fall and would provide that documentation. At 10:38 a.m., RN-B reviewed the agenda from their unit meeting (dated 1/29/26) which identified a discussion labeled, "1:1 activities / what is 1:1," and, "Prevent fractures from self-transfers," with an attached sign-in sheet listing employee names and a "X" if attended. This listing had a total of 91 active employees (as of 1/29/26) but 51 of them did not have an "X" to demonstrate re-education on the topics. RN-B stated they recalled having discussion on 1:1 at	20830		

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20830	Continued from page 8 the meeting and using teamwork to ensure supervision is provided when needed. RN-B acknowledged the multiple names on the listing without re-education and stated they were still trying to get some people caught up on it and working on a different system to get better attendance at the meetings. RN-B verified the nurses of the unit were not included in the re-education, either, since it was specific to NA staff members. When interviewed on 3/26/26 at 11:06 a.m., RN-C stated they were currently assigned to R2 and were aware R2 had fallen on the TCU prior and obtained an elbow fracture from it. RN-C stated if they directed a 1:1 for a patient then they expected the NA to have eyesight of them at all times. RN-C there had been no discussion of 1:1's or their expectation to the nurses on it recently to their recall adding, "Not that I'm aware of." On 3/24/26 at 12:04 p.m., the DON and administrator were interviewed. DON stated they did not feel the language in the FSI, and progress notes meant a direct 1:1 needed prior to R2's fall but rather the documentation supported that was maybe a new intervention to do post-fall. DON stated the NA staff may have identified R2 was restless and needed more supervision on 1/10/26 and felt they could handle it themselves. DON reiterated they did not feel the language in the chart reflected a 1:1 was needed prior to the fall. The facility LTC (Long-term Care) Falls and Accidents policy, dated 10/2024, identified supervision defined as a determination based on the individual resident's assessed needs and identified hazards in the environment. This added, "Adequate supervision may vary from resident to resident and from time to time for the same resident." The policy directed staff would be educated on preventing residents' falls and have access to the care plans for each resident. The resident would also be assessed for fall risk and based upon that, have individualized interventions in place to reduce the risk. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review or develop applicable policies on increased supervision; educate direct care staff on those procedures and then audit to ensure ongoing compliance.	20830		

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20830	Continued from page 9 TIME PERIOD FOR CORRECTION: 21 Days	20830		