DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 3, 2025

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

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

Dear Administrator:

On November 19, 2025, we informed you that we may impose enforcement remedies.

On September 19, 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).

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).

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.

NURSE AIDE TRAINING PROHIBITION

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

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

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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,

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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Re: Event ID: 1D74D0H1

Dear Administrator:

The above facility survey was completed on September 19, 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,

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/19/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 9/18/25 and 9/19/25, a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure. The following complaints were reviewed: H52434483G (2615830) with no licensing orders. Minnesota Department of Health is documenting the State	20000		

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 Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

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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 interview and record review the facility failed to ensure a mechanical lift sling was properly secured and free from entanglement hazards following transfer and/or prior to wheelchair transport for 1 of 3 residents (R1) which resulted in harm when R1's left leg became entangled in the strap which caused a traumatic hematoma on the leg that required hospitalization, surgical intervention, and blood transfusion. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance (PNC). Findings include: R1's quarterly Minium Data Set (MDS) dated 5/29/25 indicated R1 had moderately impaired cognition, required maximum assistance with mobility, and was dependent on staff for transfers using a wheelchair. Diagnoses included heart failure, peripheral vascular disease, neuropathy, arthritis, osteopenia, and chronic pain syndrome. R1's activities of daily living (ADL) care plan dated 9/27/22 identified her as at risk for ADL decline, with interventions that included the use of a full-body mechanical lift for all transfers (initiated on 4/19/23). Staff to use purple sling with green trim lift sling and to ensure straps are secured in wheelchair per residents' preference.	F0689	"Past Noncompliance - no plan of correction required"	

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.

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F0689 SS = G	Continued from page 1 The facility reported incident dated 9/11/25, identified R1 was being returned to her room by Activity Director (AD)-A following an outing when a lower sling strap became caught in the front wheel of her wheelchair, pulling R1's left lower leg backward and tightly against the chair. Nursing assistant (NA-J) was sitting at the nurses' station, heard R1 say "Ow" and observed the entanglement. NA-J immediately intervened, stopped the wheelchair and loosened the strap. At the time, no visible injury was noted by NA-J or licensed practical nurse (LPN)-A. R1's hospital discharge summary dated 9/15/25, indicated R1 experienced increased, uncontrolled pain, and was transferred to the emergency department. She was diagnosed with a traumatic hematoma, requiring incision and drainage. R1 also required a blood transfusion of 2 units, due to a hemoglobin dropping from 14 to 7.3 grams per deciliter (Normal range is 12.0 to 13.5g/dl). R1 was admitted to acute care, discharged back to the facility on 9/15/25. Hospice consult was ordered. and placed on hospice care the same day. She required ongoing daily dressing changes to the hematoma site. The facility's internal investigation dated 9/11/25, revealed the leg strap of the lift sling that had been left underneath R1 after she was transferred to the wheelchair had not been properly secured or tucked away. Interviews with AD-A and NA-J confirmed that the sling strap had fallen and became wrapped around the front wheelchair wheel, pulling R1's leg backwards. AD-A's typed statement dated 9/11/25, identified that AD-A was returning R1 to her room after an outing at approximately 2:00 p.m., when her straps from her sling dropped down and got caught in R1's front wheelchair wheel. This strap pulled R1's leg back. R1 yelled out and they stopped abruptly. NA-J was sitting at the nurses' station and assisted to get the strap out of the wheel. NA-J returned R1 to her room while AD-A informed licensed practical nurse (LPN)-A of incident. NA-J's Granite Falls Health Vulnerable Adult Witness/Report Form dated 9/12/25 was handwritten by NA-J, identified on 9/11/25 at approximately 2:40 p.m., R1 was being brought back to her room by AD-A. When they were passing the nurses' station on B wing NA-J heard R1 say "Ow". He looked over and immediately saw the left leg sling strap had fallen and was wrapped around the front wheel of R1's wheelchair. Trapping R1's left leg backwards against the wheelchair. NA-J had AD-A stop immediately and knelt in front of R1 to	F0689		

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F0689 SS = G	Continued from page 2 loosen the leg strap and re-tuck the leg strap beside R1. NA-J then took R1 back to her room and laid her down in bed. NA-J did not see any bruising, redness or swelling to site. LPN-A's Vulnerable Adult Witness/Report form dated 9/12/25, identified LPN-A was made aware of incident on 9/11/25, by activity staff that R1's sling strap got ran over and caught R1's left leg with it. LPN-A indicated she did not see redness or bruising on R1's leg. During an interview on 9/18/25 at 2:05 p.m., AD-A stated she was the staff person pushing R1 back to her room when the lower strap became entwined in the from wheel of R1's wheelchair. AD-A let NA-J take R1 back to her room while she went to LPN-A to report the incident. AD-A stated she could not remember if when unloading R1 from bus if the sling straps were hanging down but thought had she been aware she would have tucked them in. During an interview on 9/18/25 at 2:16 p.m., NA-J stated he was sitting at Nurses' station B when AD-A was pushing R1 in her wheelchair back to her room. R1' stated "Ow". NA-J looked over and saw that the lower strap of the full body lift sheet had fallen and pulled R1's left lower leg back against the chair tightly. NA-J stopped AD-A and assisted with getting the strap loosened and tucked back into the chair. NA-J took R1 back to her room and assisted her to bed. He examined the lower left leg and did not see any redness or bruising. Na-J further stated that when he had gotten R1 up for the outing, he had tucked her straps back and under R1 so they would not be hanging down. During an interview on 9/19/25 at 12:50 p.m., LPN-A stated she was made aware of incident by AD-A. When LPN-A went to look at R1's leg immediately following the incident, R1 did not complain of pain and she did not see any redness, bruising or swelling. LPN-A left that day without documenting the incident in R1's record. LPN-A stated the sling straps needed to be tucked back and under the resident to prevent them from becoming entangled in the wheelchair and/or get caught on something. During an interview on 9/19/25 at 10:59 a.m., registered nurse (RN)-A was working the evening shift on 9/11/25. Around 6:00 p.m., she was notified that R1 had pain and developed bruising. When RN-A went to assess R1, she had "increased pain" and found a hematoma on R1's left leg that seemed to have increased in size in a short time. RN-A immediately called the	F0689		

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F0689 SS = G	Continued from page 3 ambulance for transport to the emergency department. RN-A stated the staff were supposed to secure the straps back and under R1 while she was in her wheelchair, otherwise they could get caught in the wheels. Since the incident with R1, the resident who required full body lifts care plans were updated with their preference as to whether they wanted to leave the sling under them and how the straps were to be stowed. During an interview on 9/19/25 at 9:50 a.m., director of nursing (DON) stated she made aware of incident right away and implemented the “In the Moment” training with all staff working and via mass email with those that were not. DON also went to all 9 residents that required total body lifts and clarified their care plan with the preference of resident on the positioning of the straps while resident was in their wheelchairs. During an interview on 9/19/25 at 1:10 p.m., EZ Way representative (REP)-A, stated was up to facility as to whether the lift sling was kept under residents and where the ends were tucked if kept under resident. The facility identified noncompliance and immediately implemented corrective actions, including: -Conducted “Just-in-Time” training for all nursing and activity staff on 9/12/25, covering: -Proper strap placement after transfers. -Requirement to tuck in all sling straps to prevent dragging or entanglement. -If a strap is seen hanging or crossed between the legs post-transfer, staff are to tuck the straps per resident’s care plan. -Consultation with the lift manufacturer (EZ Way REP-A) confirmed the facility is responsible for determining sling storage policies and safety procedures, 9/12/25. -Director of Nursing (DON) and nursing leadership reassessed all 9 residents who use total body lifts to ensure individualized care plans included clear direction on sling storage and strap management preferences, 9/15/25. -DON ensured ongoing visual monitoring of sling use practices and documentation.	F0689		
F0000	INITIAL COMMENTS On 9/18/25 and 9/19/25, a standard abbreviated survey	F0000		

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F0000	Continued from page 4 was conducted at your facility. Your facility was found to be in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed:H52434483G (2615830) with deficiencies cited at F689 at past non-compliance (PNC). 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		