DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 28, 2021

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

RE: CCN: 245594
Cycle Start Date: March 24, 2021

Dear Administrator:

On April 27, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
April 6, 2021

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

RE: CCN: 245594
Cycle Start Date: March 24, 2021

Dear Administrator:

On March 24, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 24, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 6, 2021

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

Re: Event ID: 3DET11

Dear Administrator:

The above facility survey was completed on March 24, 2021 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/23/21 through 3/24/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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

Electronically Signed | 04/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5594020C (MN71031), however NO licensing orders were issued. Minnesota Department of Health is documenting the State 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, the facility must acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/23/21 through 3/24/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5594020C (MN71031), with deficiencies cited at F600, F607, F609, and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		4/21/21

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

Electronically Signed | 04/16/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R1) was free from verbal and physical abuse by 1 of 1 staff (nurse aide (NA)-C). The facility also failed to have a system in place to monitor for and report suspected staff burnout and ensure there was no perceived threat of staff to staff retaliation for reporting suspected abuse. Findings include: Review of the 3/17/21 4:39 p.m., report to the State Agency (SA) identified NA-A and NA-C were providing morning cares to R1. While turning R1 from side to side, R1 was handled roughly causing her head to get bumped into her side rail 4 times. R1 stated several times, her head to hurt and asked for a different care giver. R1 asked NA-C why she was so mean to her. NA-C reportedly replied "That's what you get for being a [expletive] all night". NA-C was suspended pending the investigation. Review of the 3/19/21, 5 day investigation report submitted to the SA identified the facility indicated staff failed to remove R1 from a potentially dangerous situation. NA-C was terminated. All staff were to be trained annually to abuse policies. No changes were needed to the policy or procedure. Facility interview with: 1) NA-A identified she felt NA-C had an irritated disposition that day as R1 had been on the bed pan several times during the night. NA-C was "red hot" when she and NA-A entered R1's room prior to the incident. NA-A was by R1's feet and	F 600	The Director of Nursing reviewed our facility policies and procedures with Administrator and the DON developed a new Progress Note titled Abuse/Neglect Incident Report in PointClickCare to ensure that ALL parts of the report and investigation are completed, and that reporting is done within 2 hours of incident occurring. This report method is currently being used for other types of incidents such as falls, and skin injuries; which has been an effective tool that walks staff step-by-step through the initial report. This incident report method will ensure that staff are guided through the entire process from the initial report all the way through the investigation to ensure proper handling of each incident. 1. Did you ensure that the resident was safe, removed from harm, protected from harm? Explain. 2. NOTIFICATION IMMEDIATELY: Administrator, document date and time. 3. Remove alleged perpetrator and place employee on suspension until investigation. 4. Was this reported to OHFC (SA) within 2 hours of initial report? Explain. 5. NOTIFICATION: Director of Nursing, document date and time. 6. Begin investigation IMMEDIATELY after notifying Administrator and DON. Yes/No a. Interview the initial reporter □ use interview sheets in Abuse/Neglect Binder.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 NA-C was by R1's head. When R1 was rolled to her left side her head was "rammed" into the side rail. Each time R1 was rolled to the side her head was bumped into the rail. NA-C advised NA-A she was "sick of dealing" with R1. There was no indication NA-A stopped the rough treatment and intervened to ensure the rough handling and verbal abuse stopped after the first time her head was struck into the rail. NA-A was afraid of retaliation from NA-C. NA-A assisted R1 the next day with her morning cares. R1 complained her head still hurt from the day before. 2) R1 identified she had not wanted to get NA-C in trouble when asked about the incident. R1 advised staff she was worried her glasses were bent after hitting the rail. R1 would not say if she felt NA-C was intentional in her actions, but did state "Well, i know she doesn't like me". R1 was assessed by the DON during her interview, and did say she had pain in her face 3 out of 10. No visible bruising was noted. 3) NA-C identified R1 used her call light several times that night, questioning why she wasn't fed, and thinking she was eating in her bed. In the morning, NA-C put R1 on the bed pan. R1 often leaned to her left side so she moves the resident to her right side to ensure she doesn't bump her head on her rail. NA-C called for NA-A to assist her getting R1 off her bedpan. NA-C made a point to advise NA-A to move the resident to her right side so she would not bump her hear or face on the rail. NA-A denied R1 ever hit her head and denied making the verbally abuse comment to R1. NA_C had been staying longer in the mornings as the facility was short staffed. NA-C identified R1 had asked her "Why do you hate me?" during the night and reassured R1 she did not. There was no indication staff had immediately	F 600	Yes/No b. Interview the victim (resident) - use interview sheets in Abuse/Neglect Binder. Yes/No c. Interview other residents □ use interview sheets in Abuse/Neglect Binder. Yes/No d. Interview other staff that may have witnessed the incident or other similar incidents - use the interview sheets in Abuse/Neglect Binder. Yes/No e. Interview any witnesses □ use the interview sheets in Abuse/Neglect Binder. Yes/No f. All interviews should have direct statements in quotes. Yes/No g. Interview Visitors, Family members that may have information. Yes/No h. Location of incident. i. Explain exactly what was reported by the INITIAL REPORTER □ direct statements should be in quotations. j. Were there witnesses? If so, Who? k. Explain exactly what was reported by the WITNESS/WITNESSES □ direct statements should be in quotations. l. Explain exactly what was reported by the VICTIM(RESIDENT) □ direct statements should be in quotations. m. Explain exactly what was reported by OTHER RESIDENTS □ statements should be in quotations. n. Explain exactly what was reported by VISITORS, FAMILY MEMBERS □ statements should be in quotations. o. Explain exactly what was reported by OTHER STAFF □ statements should be in quotations. p. What type of abuse occurred?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 assessed R1 head-to-toe that same morning to ensure she was not bruised elsewhere on her body from the rough cares, no indication other staff or residents were interviewed, or re-trained to facility policies. Interview on 3/23/21 at 1:34 p.m., with NA-A identified she was a NA trainee. The event occurred on 3/17/21 at approximately 9:00 a.m.. NA-A and NA-C went into R1's room. NA-A was by R1's feet and NA-C was by her head. "Every time we rolled her, [R1] hit her face on the grab bar" which was to R1's left side. R1 asked NA-C why she was so mean. NA-C replied "That's what you get for being a [expletive] all night". R1 asked for a different care giver. R1 was very distraught. Even after the incident, R1 refused to take a bath, and would not eat breakfast. She was "Very upset and teary eyed". When NA-A and NA-C left R1's room, NA-C said she was "Sick of [R1]". NA-A told another co-worker (NA-D) of the incident about 45 minutes after it occurred as NA-A wasn't sure what to do. NA-A had no retraining to facility abuse policies after the incident. The next day, NA-A and NA-B were assisting R1. R1 made the comment to "please not run my head into the bar." During morning stand-up, the overnight nurse, licensed practical nurse (LPN)-A had asked in morning report "Who tattled?!" when discussing the allegations of abuse against NA-C. NA-A felt very intimidated by LPN-A's remark. The facility just had annual training at inservices, but abuse was not covered. Interview on 3/23/21 with NA-B identified she assisted NA-A in R1's morning cares that R1 made the comment her head hurt because of NA-C "pushing her head into the rail". NA-B had only worked with NA-C one other time. NA-C	F 600	(physical, verbal, sexual, emotional, neglect, financial exploitation) q. Did the incident cause injury? Explain. r. Did a licensed nurse complete a full body assessment on the victim (resident)? s. Vital signs of the victim (resident). t. Routine medications (cardio, diuretics, narcotics, PRN meds, laxatives, diabetic, Parkinson□s, etc.). u. Psychoactive medications (antipsychotics, antianxiety, hypnotics, routine, PRN, antidepressants, etc.) v. Acute changes (UTI, syncope, weight loss, fever, URI, delirium, other infection). w. Chronic conditions (CVA, Parkinson□s, seizures, dementia, TIA, COPD, hypotension, arthritis, etc.) x. Psychological issues (anxiety, agitation, depression, failure to thrive, etc.) y. Cognitive status (alert, oriented, confused, varies, change in the last 30 days, etc.) z. Change in sleep patterns? If so, explain. aa. Judgement (poor safety awareness, good judgement, varies, makes needs known, unable) bb. Behavior/Mood problems (sundowning, wandering, agitation, hallucinations, combative, etc.) cc. Notification to LAW ENFORCEMENT (Date/Time). What was their response. dd. Notification to FAMILY (Date/Time). What was their response. ee. Notification to PRIMARY CARE PROVIDER/MD (Date/Time). What was their response.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 worked overnights. NA-B also witnessed LPN-A "yell" and "be mad" staff and asked staff in report "Who tattled?!" NA-B fears retaliation form other staff for reporting incidents. "If we dos something, one person will be mad" at them. NA-B was not spoken to by the DON during the investigation, and no re-education on abuse occurred after the incident. R1's 2/12/21, quarterly Minimum Data Set (MDS) identified she had moderate cognitive impairment with diagnoses of muscle weakness, pain, anxiety and depression. No cognitive affecting diagnoses were identified. R1 required a 2 staff assist with bed mobility, transfers, dressing and toilet use and locomotion with the use of a wheelchair. R1's nursing assessments identified there was no skin or other assessment performed since 2/12/21 to identify staff had performed a full inspection of R1 to ensure she was not injured from the rough cares. Observation and interview on 3/23/21 at 2: 44 p.m. identified R1 stated she couldn't recall the event. "I don't remember it" and stated repeatedly she didn't know anything regarding the care received on 3/17. R1 appeared hesitant to speak and would not make eye contact once asked about the allegation. When asked if she knew who she could report an abusive situation to, she replied she did not know. R1 stated she currently felt safe at the facility. R1 had no bruising or marks to indicate injuries visible at the time of the interview. R1 was alert to person, place and time and noted to be an accurate historian. R1's 3/19/21, physician (MD) visit note identified R1 was doing well and staff were concerned over	F 600	ff. Notification to NURSING ASSISTANT REGISTRY/BOARD OF NURSING? gg. Notification of OMBUDSMAN. What was their response? hh. Was the victim (resident) sent to the hospital for evaluation? Document Where, When, Date and Time. On 3/24/2021, education was provided for staff in all departments that addresses staff burnout and how to identify if a staff member is showing signs of burnout and the steps to report this to the supervisor. Following this education, supervisors were further trained on 03/30/2021, during department manager meeting, educating them on the steps to take if an employee under their supervision is experiencing burnout. All staff completed this training on 03/30/2021. To help reduce staff burnout, the Director of Nursing and Administrator have been in contact with annLeo and All Temporaries for assistance with staffing to help with staff burnout. They notified us that they did have someone that could potentially help us out. However, this person previously worked for us, was terminated and is on a no-rehire status. Administrator and Director of Nursing felt that this was not an adequate solution and asked the pool agency to find others. They were able to provide two individuals to provide minimal coverage of a couple of shifts to-date, so the Administrator initiated new contracts with KareKrest, Prime Time Healthcare and Nurzee; they are in the process of locating pool staffing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5 a UTI. R1 reported pain in all of her extremeties. There was no mention R1 reported the rough cares by NA-C to MD-A. R1's progress notes identified on: 1) 3/17/21, there is no indication staff assessed R1 for potential injuries from allegations of abuse. 2) 3/19/21, staff noted R1's urinary culture report identified she mixed bacterium, however MD-A declined to treat it at that time. There was no indication staff identified R1's additional bathroom requests as potential signs of a bladder infection. Interview on 3/23/21 at 2:54 p.m. with LPN-B identified she had not worked last week, but was aware of the allegations made towards NA-C. LPN-B identified NA-C showed signs of burnout."I could see she has been tired". NA-C was arriving for work around 9:00 p.m. to 10:30 p.m. and staying late in the mornings to assist with morning cares. NA-C was getting "lots of overtime". If she sees signs of burnout in staff, she tells them to "Go take a breather". She had told NA_C to take those additional breaks before. LPN-B acknowledged she had not advised the director of nursing (DON) of her concerns or observations of staff burnout. Interview on 3/23/21 at 3:04 p.m. with NA-C identified she worked until 11:08 a.m. that morning as there was no additional staff to do resident baths. NA-C has worked at the facility for 3 years. NA-C stated R1 had used her call light several times that night but denied the allegations of verbal and physical abuse. NA-C specifically stated she was by R1's feet and not her head as she had already finished washing the top half of R1's body. "I honestly don't remember her hitting her head. I always adjust her pillow". NA-C	F 600	to help give our staff a break to help with burnout. All-staff education and training is scheduled for April 19, 20, and 21 providing all employees the required annual facility specific Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation Policy and Procedures using the updated 2017 LeadingAge and Pathway Health edition of this policy and procedure, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedure. Zero Tolerance of Retaliation Policy Here at Gil-Mor, we will not tolerate intimidation or retaliation against anyone who raises a concern, makes a report, or cooperates in an investigation. Retaliation is not just malicious and contrary to our core values; it also undermines the culture of openness and trust we are determined to maintain. Any threat of retaliation can hinder investigations and prevent people from coming forward with concerns. Retaliation can take many forms and is sometimes subtle. It can also occur inside or outside of the workplace. In many instances, it is also illegal. Each of us has a role to play in making retaliation unacceptable and maintaining an environment in which we can all feel safe and comfortable raising an issue or reporting a violation. We recognize speaking up is not easy, however, at Gil-Mor, we want to make the decision to speak up and report concerns	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 denied feeling tired and stated she de-stresses appropriately. NA-C was suspended pending the investigation and was terminated. Review of NA-C's employee file identified she was disciplined in September of 2019 for insubordination to the charge nurse. NA-C was reprimanded for not answering a call light and eating at the nurses station during her overnight shift. The LPN directed her to answer the call light. NA-C got up, slammed her chair against the desk and stormed past the nurse. Interview on 3/23/21 at 4:37 p.m. with the DON identified NA-D had reported the incident to her at approximately 1:30 p.m. or so, just as she was getting ready to leave. The DOn had to come back to work in a few hours to cover the evening shift and advised NA-D to report the incident to the administrator. When she returned at 3:30, the administrator advised her the incident required reporting. She started her investigation and then filed the report about an hour later. Staff had abuse training online yearly but were not trained to facility abuse policies specifically. No staff were re-educated after the incident. The DOn spoke with NA-A, NA-C and NA-D. The DON was unsure how to proceed after the allegation was made as this was the first time anything like this had happened at the facility. R1's physician, MD-A is also the medical director. He and family were made aware of the incident after she reported it to the SA. The family reported R1 stated to them she was surprised her glasses weren't broke as her head hit hard. The DON agreed no formal assessment occurred immediately after the allegation was made to identify if R1 had any injuries. "I did inspect her face" when she spoke to R1, but did not do or	F 600	as simple as possible. Retaliation against anyone who raises a concern or reports a violation in good faith may result in disciplinary action, up to and including termination of employment. For all newly hired employees, our Staff Development-RN will ensure that all new employees receive training on our facility specific Abuse and Neglect policy and procedures, they will receive a copy of the Abuse and Neglect packet that includes the quiz to test their knowledge and understanding. Also, SD-RN will ensure that new hires understand and are competent and stress the importance of understanding that every employee is a mandated reporter and there is a zero tolerance of retaliation policy. If abuse is suspected it must be REPORTED IMMEDIATELY to the Charge Nurse, Administrator and DON, keeping the resident safe and removing them from danger immediately. In the event abuse or neglect is reported to the charge nurse, the charge nurse will follow chain of command and report it immediately to the Administrator and Director of Nursing. The Administrator and DON is responsible for reporting the incident within 2 hours of notification to the State Agency/OHFC and completion of the follow-up investigation within 5 days. On 03/24/2021, all employees were given an educational packet titled, Job Burnout: How to spot it and take action educational information. We then tested their knowledge and understanding by having	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 delegate a formal assessment for injuries for R1. The DON was unaware of how to monitor staff for burnout. There was no policy she was aware of for that. The DON stated all staff are over worked related to the pandemic. The facility does have a contract for pool staff, but the workers are unreliable so they do not use them often at all. They advertise for help in the paper. The facility just had annual inservices, but abuse was not discussed as they focused on the pandemic needs. Staff were trained online yearly in a generalized training. The DON indicated she suspected the allegation to be true and had terminated NA-C's employment. The DON had not reported her findings to law enforcement or the nurse aide registry. She was unaware the facility policies had not been reviewed yearly as required by federal regulation. She agreed facility policy had not been followed at the time of the incident related to reporting, keeping the resident safe, and investigation. Interview and document review on 3/24/21 at 11:39 a.m. with MD-A identified he was made aware of the allegations. He was unsure what interventions staff placed for R1's safety. He agreed burnout was a likely cause of the abuse. He was unaware the facility had no policy, plan, or procedure related to staff burnout and was unaware staff were not specifically trained to facility abuse policies. He agreed the facility failed to follow their abuse policies as identified below. Review of the 1/9/14, Vulnerable Adult policy identified any suspected abuse, neglect, or mistreatment was to be reported immediately to the charge nurse, who was to then notify the administrator and DON immediately after becoming aware of the allegation. Abuse was	F 600	each employee complete the Burnout Quiz. Included in this information was who to contact and how to ask for help, additional steps to take to de-stress, and additional methods for stress management. Then on 03/30/2021, all supervisors received additional Burnout education and training on how to identify any indicators, signs and symptoms of their employees suffering from burnout. Our Staff Development-RN provided all employees educational and information on stress management that identified different places and methods to help relieve stress. Below is information regarding stress management and methods of relaxation, provided over the past year to employees. " 5/5/2020 Mental Health and Psyco-social considerations during COVID-19 " 5/15/2020 Free information provided from Dr. Samantha Peterson, Psychologist; American Red Cross □ Supporting yourself and others during COVID-19, University of Toronto - Mind Control: Managing Your Mental Health During COVID-19, Beck Institute (Beck Cognitive Behavioral Therapy) □ Managing Mental Health in the Workplace, 10 Virtual Therapy and Mental Health Apps to Cope with Coronavirus Stress, CBT for Front-line Medical Professionals: Brief Interventions during a time of crisis, CBT Substance Use Disorders during the COVID-19 Crisis (2-part series) " 01/11/2021 Statewide Healthcare	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8 defined as conduct which was not an accident that produces or could produce pain, injury or emotional distress. The administrator or designee was to report the incident to the SA. In cases of abuse where there was a potential for harm , staff were to take immediate steps to protect the resident. The administrator or designee was to interview victims, employees, witnesses, family members, visitors, etc. Review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified abuse was defined as intentional mistreatment that could or did result in physical pain, injury and causes or reasonably expected to cause mental or emotional damage to the resident. All new employees were to be oriented to the Resident Protection Plan and made aware of their responsibility to report any suspected maltreatment as defined and described in this plan. Yearly inservices on the facility abuse policy was mandatory for all employees. The policy was to be posted in a conspicuous location in the facility. All reports of suspected crimes or abuse were to be reported immediately to law enforcement to be investigated. Immediately upon receiving a report, nursing staff were to remove the resident from the situation./ Employees were to be immediately removed from the facility pending investigation. and staff were to examine, assess and interview the resident to determine injury. There was to be no retaliation for an employee who makes a report. Further review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified results of the investigation were to be reported within 5 days to	F 600	Coordination Center□s Behavioral Health Staff Wellness Group □ Reaching for a Calm 21 Brown Bag Series " 01/25/2021 Offered two links on videos to help you relax " 01/25/2021 through 01/29/2021 Gil-Mor set-up a Relaxation Room for staff to show examples of how aromatherapy and a relaxation video. Provided Relaxation and Rest information that described how getting 8 hours of sleep every night is best for good health, your immune system works better if you relax and unwind, and while adrenalin, norepinephrine and cortisol are released when a person does physical activity, these are healthy levels. When you are constantly stressed, these hormones are still released and increases the risk of developing heart disease. These hormones can start affecting your ability to sleep. The immune system loses the inflammation phase of healing when cortisol is in high levels in your blood this is one of the necessary phases of healing for our immune system " On 03/01/2021, all staff received a survey to complete to help our facility management staff identify areas needing attention or improvement. Survey questions were as follows: o What do you enjoy about working at Gil-Mor? o What do you feel is the most difficult part of your job here at Gil-Mor? o What changes would make things better for you in the work environment? o What do feel empowers you to continue to work as a Gil-Mor employee?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 the SA and was to include: 1) Name and age of resident 2) Cognitive level 3) description of the incident 4) date and time of incident 5) Where it took place. 6) type and location of injuries of any. 7) Name of person who discovered/observed the incident 8) Name of person incident reported to. 9) Names of people outside the facility who were notified including police, physicians, family members. Substantiated complaints against other employees were to be reported to the respective boards. Review of the undated Incident Report Guide identified after an allegation of abuse was made, staff were to protect the resident first. Next, they were to interview the alleged perpetrator (AP). Staff were to assess the resident and document findings. All staff were to be interviewed, and reports to the SA and law enforcement were to be made.	F 600	o What could Gil-Mor do more of or better to help you feel empowered? o Would you be interested in becoming a mentor for new staff? " On 3/24/2021 Educational information called Job Burnout: How to spot it and take action, as well as testing employees knowledge and understanding through the Burnout quiz. " On 03/30/2021 Additional Burnout education and training was provided to all Department Managers to help them identify any indicators, signs and symptoms of their employees suffering from burnout. On an annual basis, the Staff Development-RN will be responsible for setting up in-service meetings to offer all annually required education and training as required by our state and federal licensure such as our facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, Vulnerable Adult, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedures. As of 03/24/2021 and ongoing the Staff Development-RN will be responsible for all new hire education and training and will ensure that all new hires receive all required training for our state and federal licensure. This plan of correction includes the following education topics and training to test their knowledge and understanding of each topic: - Vulnerable Adult - Facility specific Abuse, Neglect,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600	Mistreatment and Misappropriation of Resident Property - Abuse Prevention - Mandatory reporting and Zero Tolerance of Retaliation All newly hired employee personnel files will be audited by the Director of Nursing/Supervisor or designee to ensure that all education and training above has been completed and a quarterly report will be submitted to the quarterly Quality Assurance Committee for review. The Gil-Mor facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy and Procedures are prominently posted for all residents on the dining room bulletin board and for all employees in the employee break room and on the employee bulletin board located by the timeclock. All incidents of abuse or neglect will be reviewed and discussed during our weekly interdisciplinary team meetings and a quarterly summary report of all reportable incidents will be brought to the quarterly Quality Assurance meeting for review and discussion. The completion date for correction of this deficiency is 04/21/2021.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		4/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 11 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies to ensure 1 of 1 staff (nurse aide (NA)-A) and 1 of 1 director of nursing (DON) were trained to facility abuse policies prior to an allegation of abuse. In addition, the facility failed to ensure R1 was immediately protected from potential further abuse and have a method to monitor for staff burnout and ensure staff felt free from potential retaliation. Findings include: Review of the 3/17/21 4:39 p.m., report to the State Agency (SA) identified NA-A and NA-C were providing morning cares to R1. While turning R1 from side to side, R1 was handled roughly causing her head to get bumped into her side rail 4 times. R1 stated several times, her head to hurt and asked for a different care giver. R1 asked NA-C why she was so mean to her. NA-C reportedly replied "That's what you get for being a [expletive] all night". NA-C was suspended pending the investigation. Review of the 3/19/21, 5 day investigation report submitted to the SA identified the facility indicated	F 607	The Director of Nursing reviewed our facility policies and procedures with Administrator and the DON developed a new Progress Note titled Abuse/Neglect Incident Report in PointClickCare to ensure that ALL parts of the report and investigation are completed, and that reporting is done within 2 hours of incident occurring. This report method is currently being used for other types of incidents such as falls, and skin injuries; which has been an effective tool that walks staff step-by-step through the initial report. This incident report method will ensure that staff are guided through the entire process from the initial report all the way through the investigation to ensure proper handling of each incident. 1. Did you ensure that the resident was safe, removed from harm, protected from harm? Explain. 2. NOTIFICATION IMMEDIATELY: Administrator, document date and time. 3. Remove alleged perpetrator and place employee on suspension until investigation. 4. Was this reported to OHFC (SA)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 12 staff failed to remove R1 from a potentially dangerous situation. NA-C was terminated. All staff were to be trained annually to abuse policies. No changes were needed to the policy or procedure. Facility interview with: 1) NA-A identified she felt NA-C had an irritated disposition that day as R1 had been on the bed pan several times during the night. NA-C was "red hot" when she and NA-A entered R1's room prior to the incident. NA-A was by R1's feet and NA-C was by R1's head. When R1 was rolled to her left side her head was "rammed" into the side rail. Each time R1 was rolled to the side her head was bumped into the rail. NA-C advised NA-A she was "sick of dealing" with R1. There was no indication NA-A stopped the rough treatment and intervened to ensure the rough handling and verbal abuse stopped after the first time her head was struck into the rail. NA-A was afraid of retaliation from NA-C. NA-A assisted R1 the next day with her morning cares. R1 complained her head still hurt from the day before. 2) R1 identified she had not wanted to get NA-C in trouble when asked about the incident. R1 advised staff she was worried her glasses were bent after hitting the rail. R1 would not say if she felt NA-C was intentional in her actions, but did state "Well, i know she doesn't like me". R1 was assessed by the DON during her interview, and did say she had pain in her face 3 out of 10. No visible bruising was noted. 3) NA-C identified R1 used her call light several times that night, questioning why she wasn't fed, and thinking she was eating in her bed. In the morning, NA-C put R1 on the bed pan. R1 often leaned to her left side so she moves the resident to her right side to ensure she doesn't bump her head on her rail. NA-C called for NA-A to assist her getting R1 off her bedpan. NA-C made a point	F 607	within 2 hours of initial report? Explain. 5. NOTIFICATION: Director of Nursing, document date and time. 6. Begin investigation IMMEDIATELY after notifying Administrator and DON. Yes/No a. Interview the initial reporter □ use interview sheets in Abuse/Neglect Binder. Yes/No b. Interview the victim (resident) - use interview sheets in Abuse/Neglect Binder. Yes/No c. Interview other residents □ use interview sheets in Abuse/Neglect Binder. Yes/No d. Interview other staff that may have witnessed the incident or other similar incidents - use the interview sheets in Abuse/Neglect Binder. Yes/No e. Interview any witnesses □ use the interview sheets in Abuse/Neglect Binder. Yes/No f. All interviews should have direct statements in quotes. Yes/No g. Interview Visitors, Family members that may have information. Yes/No h. Location of incident. i. Explain exactly what was reported by the INITIAL REPORTER □ direct statements should be in quotations. j. Were there witnesses? If so, Who? k. Explain exactly what was reported by the WITNESS/WITNESSES □ direct statements should be in quotations. l. Explain exactly what was reported by the VICTIM(RESIDENT) □ direct statements should be in quotations. m. Explain exactly what was reported by OTHER RESIDENTS □ statements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 13 to advise NA-A to move the resident to her right side so she would not bump her hear or face on the rail. NA-A denied R1 ever hit her head and denied making the verbally abuse comment to R1. NA_C had been staying longer in the mornings as the facility was short staffed. NA-C identified R1 had asked her "Why do you hate me?" during the night and reassured R1 she did not. There was no indication staff had immediately assessed R1 head-to-toe that same morning to ensure she was not bruised elsewhere on her body from the rough cares, no indication other staff or residents were interviewed, or re-trained to facility policies. Interview on 3/23/21 at 1:34 p.m., with NA-A identified she was a NA trainee. The event occurred on 3/17/21 at approximately 9:00 a.m.. NA-A and NA-C went into R1's room. NA-A was by R1's feet and NA-C was by her head. "Every time we rolled her, [R1] hit her face on the grab bar" which was to R1's left side. R1 asked NA-C why she was so mean. NA-C replied "That's what you get for being a [expletive] all night". R1 asked for a different care giver. R1 was very distraught. Even after the incident, R1 refused to take a bath, and would not eat breakfast. She was "Very upset and teary eyed". When NA-A and NA-C left R1's room, NA-C said she was "Sick of [R1]". NA-A told another co-worker (NA-D) of the incident about 45 minutes after it occurred as NA-A wasn't sure what to do. NA-A had no retraining to facility abuse policies after the incident. The next day, NA-A and NA-B were assisting R1. R1 made the comment to "please not run my head into the bar." During morning stand-up, the overnight nurse, licensed practical nurse (LPN)-A had asked in morning report "Who tattled?!" when	F 607	should be in quotations. n. Explain exactly what was reported by VISITORS, FAMILY MEMBERS □ statements should be in quotations. o. Explain exactly what was reported by OTHER STAFF □ statements should be in quotations. p. What type of abuse occurred? (physical, verbal, sexual, emotional, neglect, financial exploitation) q. Did the incident cause injury? Explain. r. Did a licensed nurse complete a full body assessment on the victim (resident)? s. Vital signs of the victim (resident). t. Routine medications (cardio, diuretics, narcotics, PRN meds, laxatives, diabetic, Parkinson□s, etc.). u. Psychoactive medications (antipsychotics, antianxiety, hypnotics, routine, PRN, antidepressants, etc.) v. Acute changes (UTI, syncope, weight loss, fever, URI, delirium, other infection). w. Chronic conditions (CVA, Parkinson□s, seizures, dementia, TIA, COPD, hypotension, arthritis, etc.) x. Psychological issues (anxiety, agitation, depression, failure to thrive, etc.) y. Cognitive status (alert, oriented, confused, varies, change in the last 30 days, etc.) z. Change in sleep patterns? If so, explain. aa. Judgement (poor safety awareness, good judgement, varies, makes needs known, unable) bb. Behavior/Mood problems (sundowning, wandering, agitation,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 14 discussing the allegations of abuse against NA-C. NA-A felt very intimidated by LPN-A's remark. The facility just had annual training at inservices, but abuse was not covered. Interview on 3/23/21 with NA-B identified she assisted NA-A in R1's morning cares that R1 made the comment her head hurt because of NA-C "pushing her head into the rail". NA-B had only worked with NA-C one other time. NA-C worked overnights. NA-B also witnessed LPN-A "yell" and "be mad" staff and asked staff in report "Who tattled?!" NA-B fears retaliation form other staff for reporting incidents. "If we dos something, one person will be mad" at them. NA-B was not spoken to by the DON during the investigation, and no re-education on abuse occurred after the incident. R1's 2/12/21, quarterly Minimum Data Set (MDS) identified she had moderate cognitive impairment with diagnoses of muscle weakness, pain, anxiety and depression. No cognitive affecting diagnoses were identified. R1 required a 2 staff assist with bed mobility, transfers, dressing and toilet use and locomotion with the use of a wheelchair. R1's nursing assessments identified there was no skin or other assessment performed since 2/12/21 to identify staff had performed a full inspection of R1 to ensure she was not injured from the rough cares. Observation and interview on 3/23/21 at 2: 44 p.m. identified R1 stated she couldn't recall the event. "I don't remember it" and stated repeatedly she didn't know anything regarding the care received on 3/17. R1 appeared hesitant to speak and would not make eye contact once asked	F 607	hallucinations, combative, etc.) cc. Notification to LAW ENFORCEMENT (Date/Time). What was their response. dd. Notification to FAMILY (Date/Time). What was their response. ee. Notification to PRIMARY CARE PROVIDER/MD (Date/Time). What was their response. ff. Notification to NURSING ASSISTANT REGISTRY/BOARD OF NURSING? gg. Notification of OMBUDSMAN. What was their response? hh. Was the victim (resident) sent to the hospital for evaluation? Document Where, When, Date and Time. On 3/24/2021, education was provided for staff in all departments that addresses staff burnout and how to identify if a staff member is showing signs of burnout and the steps to report this to the supervisor. Following this education, supervisors were further trained on 03/30/2021, during department manager meeting, educating them on the steps to take if an employee under their supervision is experiencing burnout. All staff completed this training on 03/30/2021. To help reduce staff burnout, the Director of Nursing and Administrator have been in contact with annLeo and All Temporaries for assistance with staffing to help with staff burnout. They notified us that they did have someone that could potentially help us out. However, this person previously worked for us, was terminated and is on a no-rehire status. Administrator and Director of Nursing felt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 15 about the allegation. When asked if she knew who she could report an abusive situation to, she replied she did not know. R1 stated she currently felt safe at the facility. R1 had no bruising or marks to indicate injuries visible at the time of the interview. R1 was alert to person, place and time and noted to be an accurate historian. R1's 3/19/21, physician (MD) visit note identified R1 was doing well and staff were concerned over a UTI. R1 reported pain in all of her extremeties. There was no mention R1 reported the rough cares by NA-C to MD-A. R1's progress notes identified on: 1) 3/17/21, there is no indication staff assessed R1 for potential injuries from allegations of abuse. 2) 3/19/21, staff noted R1's urinary culture report identified she mixed bacterium, however MD-A declined to treat it at that time. There was no indication staff identified R1's additional bathroom requests as potential signs of a bladder infection. Interview on 3/23/21 at 2:54 p.m. with LPN-B identified she had not worked last week, but was aware of the allegations made towards NA-C. LPN-B identified NA-C showed signs of burnout."I could see she has been tired". NA-C was arriving for work around 9:00 p.m. to 10:30 p.m. and staying late in the mornings to assist with morning cares. NA-C was getting "lots of overtime". If she sees signs of burnout in staff, she tells them to "Go take a breather". She had told NA_C to take those additional breaks before. LPN-B acknowledged she had not advised the director of nursing (DON) of her concerns or observations of staff burnout. Interview on 3/23/21 at 3:04 p.m. with NA-C	F 607	that this was not an adequate solution and asked the pool agency to find others. They were able to provide two individuals to provide minimal coverage of a couple of shifts to-date, so the Administrator initiated new contracts with KareKrest, Prime Time Healthcare and Nurzee; they are in the process of locating pool staffing to help give our staff a break to help with burnout. All-staff education and training is scheduled for April 19, 20, and 21 providing all employees the required annual facility specific Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation Policy and Procedures using the updated 2017 LeadingAge and Pathway Health edition of this policy and procedure, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedure. Zero Tolerance of Retaliation Policy Here at Gil-Mor, we will not tolerate intimidation or retaliation against anyone who raises a concern, makes a report, or cooperates in an investigation. Retaliation is not just malicious and contrary to our core values; it also undermines the culture of openness and trust we are determined to maintain. Any threat of retaliation can hinder investigations and prevent people from coming forward with concerns. Retaliation can take many forms and is sometimes subtle. It can also occur inside or outside of the workplace. In many instances, it is also illegal. Each of us has a role to play	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 16 identified she worked until 11:08 a.m. that morning as there was no additional staff to do resident baths. NA-C has worked at the facility for 3 years. NA-C stated R1 had used her call light several times that night but denied the allegations of verbal and physical abuse. NA-C specifically stated she was by R1's feet and not her head as she had already finished washing the top half of R1's body. "I honestly don't remember her hitting her head. I always adjust her pillow". NA-C denied feeling tired and stated she de-stresses appropriately. NA-C was suspended pending the investigation and was terminated. Review of NA-C's employee file identified she was disciplined in September of 2019 for insubordination to the charge nurse. NA-C was reprimanded for not answering a call light and eating at the nurses station during her overnight shift. The LPN directed her to answer the call light. NA-C got up, slammed her chair against the desk and stormed past the nurse. Interview on 3/23/21 at 4:37 p.m. with the DON identified NA-D had reported the incident to her at approximately 1:30 p.m. or so, just as she was getting ready to leave. The DOn had to come back to work in a few hours to cover the evening shift and advised NA-D to report the incident to the administrator. When she returned at 3:30, the administrator advised her the incident required reporting. She started her investigation and then filed the report about an hour later. Staff had abuse training online yearly but were not trained to facility abuse policies specifically. No staff were re-educated after the incident. The DOn spoke with NA-A, NA-C and NA-D. The DON was unsure how to proceed after the allegation was made as this was the first time anything like this	F 607	in making retaliation unacceptable and maintaining an environment in which we can all feel safe and comfortable raising an issue or reporting a violation. We recognize speaking up is not easy, however, at Gil-Mor, we want to make the decision to speak up and report concerns as simple as possible. Retaliation against anyone who raises a concern or reports a violation in good faith may result in disciplinary action, up to and including termination of employment. For all newly hired employees, our Staff Development-RN will ensure that all new employees receive training on our facility specific Abuse and Neglect policy and procedures, they will receive a copy of the Abuse and Neglect packet that includes the quiz to test their knowledge and understanding. Also, SD-RN will ensure that new hires understand and are competent and stress the importance of understanding that every employee is a mandated reporter and there is a zero tolerance of retaliation policy. If abuse is suspected it must be REPORTED IMMEDIATELY to the Charge Nurse, Administrator and DON, keeping the resident safe and removing them from danger immediately. In the event abuse or neglect is reported to the charge nurse, the charge nurse will follow chain of command and report it immediately to the Administrator and Director of Nursing. The Administrator and DON is responsible for reporting the incident within 2 hours of notification to the State Agency/OHFC and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 17 had happened at the facility. R1's physician, MD-A is also the medical director. He and family were made aware of the incident after she reported it to the SA. The family reported R1 stated to them she was surprised her glasses weren't broke as her head hit hard. The DON agreed no formal assessment occurred immediately after the allegation was made to identify if R1 had any injuries. "I did inspect her face" when she spoke to R1, but did not do or delegate a formal assessment for injuries for R1. The DON was unaware of how to monitor staff for burnout. There was no policy she was aware of for that. The DON stated all staff are over worked related to the pandemic. The facility does have a contract for pool staff, but the workers are unreliable so they do not use them often at all. They advertise for help in the paper. The facility just had annual inservices, but abuse was not discussed as they focused on the pandemic needs. Staff were trained online yearly in a generalized training. The DON indicated she suspected the allegation to be true and had terminated NA-C's employment. The DON had not reported her findings to law enforcement or the nurse aide registry. She was unaware the facility policies had not been reviewed yearly as required by federal regulation. She agreed facility policy had not been followed at the time of the incident related to reporting, keeping the resident safe, and investigation. Interview and document review on 3/24/21 at 11:39 a.m. with MD-A identified he was made aware of the allegations. He was unsure what interventions staff placed for R1's safety. He agreed burnout was a likely cause of the abuse. He was unaware the facility had no policy, plan, or procedure related to staff burnout and was	F 607	completion of the follow-up investigation within 5 days. On 03/24/2021, all employees were given an educational packet titled, Job Burnout: How to spot it and take action educational information. We then tested their knowledge and understanding by having each employee complete the Burnout Quiz. Included in this information was who to contact and how to ask for help, additional steps to take to de-stress, and additional methods for stress management. Then on 03/30/2021, all supervisors received additional Burnout education and training on how to identify any indicators, signs and symptoms of their employees suffering from burnout. Our Staff Development-RN provided all employees educational and information on stress management that identified different places and methods to help relieve stress. Below is information regarding stress management and methods of relaxation, provided over the past year to employees. " 5/5/2020 Mental Health and Psyco-social considerations during COVID-19 " 5/15/2020 Free information provided from Dr. Samantha Peterson, Psychologist; American Red Cross Supporting yourself and others during COVID-19, University of Toronto - Mind Control: Managing Your Mental Health During COVID-19, Beck Institute (Beck Cognitive Behavioral Therapy) Managing Mental Health in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 18 unaware staff were not specifically trained to facility abuse policies. He agreed the facility failed to follow their abuse policies as identified below. Review of the 1/9/14, Vulnerable Adult policy identified any suspected abuse, neglect, or mistreatment was to be reported immediately to the charge nurse, who was to then notify the administrator and DON immediately after becoming aware of the allegation. Abuse was defined as conduct which was not an accident that produces or could produce pain, injury or emotional distress. The administrator or designee was to report the incident to the SA. In cases of abuse where there was a potential for harm , staff were to take immediate steps to protect the resident. The administrator or designee was to interview victims, employees, witnesses, family members, visitors, etc. Review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified abuse was defined as intentional mistreatment that could or did result in physical pain, injury and causes or reasonably expected to cause mental or emotional damage to the resident. All new employees were to be oriented to the Resident Protection Plan and made aware of their responsibility to report any suspected maltreatment as defined and described in this plan. Yearly inservices on the facility abuse policy was mandatory for all employees. The policy was to be posted in a conspicuous location in the facility. All reports of suspected crimes or abuse were to be reported immediately to law enforcement to be investigated. Immediately upon receiving a report, nursing staff were to remove the resident from the situation./ Employees were to be immediately	F 607	Workplace, 10 Virtual Therapy and Mental Health Apps to Cope with Coronavirus Stress, CBT for Front-line Medical Professionals: Brief Interventions during a time of crisis, CBT Substance Use Disorders during the COVID-19 Crisis (2-part series) " 01/11/2021 Statewide Healthcare Coordination Center□s Behavioral Health Staff Wellness Group □ Reaching for a Calm 21 Brown Bag Series " 01/25/2021 Offered two links on videos to help you relax " 01/25/2021 through 01/29/2021 Gil-Mor set-up a Relaxation Room for staff to show examples of how aromatherapy and a relaxation video. Provided Relaxation and Rest information that described how getting 8 hours of sleep every night is best for good health, your immune system works better if you relax and unwind, and while adrenalin, norepinephrine and cortisol are released when a person does physical activity, these are healthy levels. When you are constantly stressed, these hormones are still released and increases the risk of developing heart disease. These hormones can start affecting your ability to sleep. The immune system loses the inflammation phase of healing when cortisol is in high levels in your blood this is one of the necessary phases of healing for our immune system " On 03/01/2021, all staff received a survey to complete to help our facility management staff identify areas needing attention or improvement. Survey questions were as follows:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 19 removed from the facility pending investigation. and staff were to examine, assess and interview the resident to determine injury. There was to be no retaliation for an employee who makes a report. Further review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified results of the investigation were to be reported within 5 days to the SA and was to include: 1) Name and age of resident 2) Cognitive level 3) description of the incident 4) date and time of incident 5) Where it took place. 6) type and location of injuries of any. 7) Name of person who discovered/observed the incident 8) Name of person incident reported to. 9) Names of people outside the facility who were notified including police, physicians, family members. Substantiated complaints against other employees were to be reported to the respective boards. Review of the undated Incident Report Guide identified after an allegation of abuse was made, staff were to protect the resident first. Next, they were to interview the alleged perpetrator (AP). Staff were to assess the resident and document findings. All staff were to be interviewed, and reports to the SA and law enforcement were to be made.	F 607	o What do you enjoy about working at Gil-Mor? o What do you feel is the most difficult part of your job here at Gil-Mor? o What changes would make things better for you in the work environment? o What do feel empowers you to continue to work as a Gil-Mor employee? o What could Gil-Mor do more of or better to help you feel empowered? o Would you be interested in becoming a mentor for new staff? " On 3/24/2021 Educational information called Job Burnout: How to spot it and take action, as well as testing employees knowledge and understanding through the Burnout quiz. " On 03/30/2021 Additional Burnout education and training was provided to all Department Managers to help them identify any indicators, signs and symptoms of their employees suffering from burnout. On an annual basis, the Staff Development-RN will be responsible for setting up in-service meetings to offer all annually required education and training as required by our state and federal licensure such as our facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, Vulnerable Adult, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedures. As of 03/24/2021 and ongoing the Staff Development-RN will be responsible for all new hire education and training and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 20	F 607	ensure that all new hires receive all required training for our state and federal licensure. This plan of correction includes the following education topics and training to test their knowledge and understanding of each topic: - Vulnerable Adult - Facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property - Abuse Prevention - Mandatory reporting and Zero Tolerance of Retaliation All newly hired employee personnel files will be audited by the Director of Nursing/Supervisor or designee to ensure that all education and training above has been completed and a quarterly report will be submitted to the quarterly Quality Assurance Committee for review. The Gil-Mor facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy and Procedures are prominently posted for all residents on the dining room bulletin board and for all employees in the employee break room and on the employee bulletin board located by the timeclock. All incidents of abuse or neglect will be reviewed and discussed during our weekly interdisciplinary team meetings and a quarterly summary report of all reportable incidents will be brought to the quarterly Quality Assurance meeting for review and discussion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 21	F 607	The completion date for correction of this deficiency is 04/21/2021.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to timely report an allegation of physical and verbal abuse for 1 of 1	F 609	The Director of Nursing reviewed our facility policies and procedures with Administrator and the DON developed a	4/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 22 resident (R1) to the State Agency (SA) and law enforcement. Findings include: Review of the 3/17/21 4:39 p.m., report to the State Agency (SA) identified NA-A and NA-C were providing morning cares to R1. While turning R1 from side to side, R1 was handled roughly causing her head to get bumped into her side rail 4 times. R1 stated several times, her head to hurt and asked for a different care giver. R1 asked NA-C why she was so mean to her. NA-C reportedly replied "That's what you get for being a [expletive] all night". NA-C was suspended pending the investigation. Review of the 3/19/21, 5 day investigation report submitted to the SA identified the facility indicated staff failed to remove R1 from a potentially dangerous situation. NA-C was terminated. All staff were to be trained annually to abuse policies. No changes were needed to the policy or procedure. Facility interview with: 1) NA-A identified she felt NA-C had an irritated disposition that day as R1 had been on the bed pan several times during the night. NA-C was "red hot" when she and NA-A entered R1's room prior to the incident. NA-A was by R1's feet and NA-C was by R1's head. When R1 was rolled to her left side her head was "rammed" into the side rail. Each time R1 was rolled to the side her head was bumped into the rail. NA-C advised NA-A she was "sick of dealing" with R1. There was no indication NA-A stopped the rough treatment and intervened to ensure the rough handling and verbal abuse stopped after the first time her head was struck into the rail. NA-A was afraid of retaliation from NA-C. NA-A assisted R1 the next	F 609	new Progress Note titled Abuse/Neglect Incident Report in PointClickCare to ensure that ALL parts of the report and investigation are completed, and that reporting is done within 2 hours of incident occurring. This report method is currently being used for other types of incidents such as falls, and skin injuries; which has been an effective tool that walks staff step-by-step through the initial report. This incident report method will ensure that staff are guided through the entire process from the initial report all the way through the investigation to ensure proper handling of each incident. 1. Did you ensure that the resident was safe, removed from harm, protected from harm? Explain. 2. NOTIFICATION IMMEDIATELY: Administrator, document date and time. 3. Remove alleged perpetrator and place employee on suspension until investigation. 4. Was this reported to OHFC (SA) within 2 hours of initial report? Explain. 5. NOTIFICATION: Director of Nursing, document date and time. 6. Begin investigation IMMEDIATELY after notifying Administrator and DON. Yes/No a. Interview the initial reporter □ use interview sheets in Abuse/Neglect Binder. Yes/No b. Interview the victim (resident) - use interview sheets in Abuse/Neglect Binder. Yes/No c. Interview other residents □ use interview sheets in Abuse/Neglect Binder. Yes/No	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 23 day with her morning cares. R1 complained her head still hurt from the day before. 2) R1 identified she had not wanted to get NA-C in trouble when asked about the incident. R1 advised staff she was worried her glasses were bent after hitting the rail. R1 would not say if she felt NA-C was intentional in her actions, but did state "Well, i know she doesn't like me". R1 was assessed by the DON during her interview, and did say she had pain in her face 3 out of 10. No visible bruising was noted. 3) NA-C identified R1 used her call light several times that night, questioning why she wasn't fed, and thinking she was eating in her bed. In the morning, NA-C put R1 on the bed pan. R1 often leaned to her left side so she moves the resident to her right side to ensure she doesn't bump her head on her rail. NA-C called for NA-A to assist her getting R1 off her bedpan. NA-C made a point to advise NA-A to move the resident to her right side so she would not bump her hear or face on the rail. NA-A denied R1 ever hit her head and denied making the verbally abuse comment to R1. NA_C had been staying longer in the mornings as the facility was short staffed. NA-C identified R1 had asked her "Why do you hate me?" during the night and reassured R1 she did not. There was no indication staff had immediately assessed R1 head-to-toe that same morning to ensure she was not bruised elsewhere on her body from the rough cares, no indication other staff or residents were interviewed, or re-trained to facility policies. Interview on 3/23/21 at 1:34 p.m., with NA-A identified she was a NA trainee. The event occurred on 3/17/21 at approximately 9:00 a.m.. NA-A and NA-C went into R1's room. NA-A was	F 609	d. Interview other staff that may have witnessed the incident or other similar incidents - use the interview sheets in Abuse/Neglect Binder. Yes/No e. Interview any witnesses □ use the interview sheets in Abuse/Neglect Binder. Yes/No f. All interviews should have direct statements in quotes. Yes/No g. Interview Visitors, Family members that may have information. Yes/No h. Location of incident. i. Explain exactly what was reported by the INITIAL REPORTER □ direct statements should be in quotations. j. Were there witnesses? If so, Who? k. Explain exactly what was reported by the WITNESS/WITNESSES □ direct statements should be in quotations. l. Explain exactly what was reported by the VICTIM(RESIDENT) □ direct statements should be in quotations. m. Explain exactly what was reported by OTHER RESIDENTS □ statements should be in quotations. n. Explain exactly what was reported by VISITORS, FAMILY MEMBERS □ statements should be in quotations. o. Explain exactly what was reported by OTHER STAFF □ statements should be in quotations. p. What type of abuse occurred? (physical, verbal, sexual, emotional, neglect, financial exploitation) q. Did the incident cause injury? Explain. r. Did a licensed nurse complete a full body assessment on the victim (resident)? s. Vital signs of the victim (resident).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 24 by R1's feet and NA-C was by her head. "Every time we rolled her, [R1] hit her face on the grab bar" which was to R1's left side. R1 asked NA-C why she was so mean. NA-C replied "That's what you get for being a [expletive] all night". R1 asked for a different care giver. R1 was very distraught. Even after the incident, R1 refused to take a bath, and would not eat breakfast. She was "Very upset and teary eyed". When NA-A and NA-C left R1's room, NA-C said she was "Sick of [R1]". NA-A told another co-worker (NA-D) of the incident about 45 minutes after it occurred as NA-A wasn't sure what to do. NA-A had no retraining to facility abuse policies after the incident. The next day, NA-A and NA-B were assisting R1. R1 made the comment to "please not run my head into the bar." During morning stand-up, the overnight nurse, licensed practical nurse (LPN)-A had asked in morning report "Who tattled?!" when discussing the allegations of abuse against NA-C. NA-A felt very intimidated by LPN-A's remark. The facility just had annual training at inservices, but abuse was not covered. Interview on 3/23/21 with NA-B identified she assisted NA-A in R1's morning cares that R1 made the comment her head hurt because of NA-C "pushing her head into the rail". NA-B had only worked with NA-C one other time. NA-C worked overnights. NA-B also witnessed LPN-A "yell" and "be mad" staff and asked staff in report "Who tattled?!" NA-B fears retaliation form other staff for reporting incidents. "If we dos something, one person will be mad" at them. NA-B was not spoken to by the DON during the investigation, and no re-education on abuse occurred after the incident. R1's 2/12/21, quarterly Minimum Data Set (MDS)	F 609	t. Routine medications (cardio, diuretics, narcotics, PRN meds, laxatives, diabetic, Parkinson□s, etc.). u. Psychoactive medications (antipsychotics, antianxiety, hypnotics, routine, PRN, antidepressants, etc.) v. Acute changes (UTI, syncope, weight loss, fever, URI, delirium, other infection). w. Chronic conditions (CVA, Parkinson□s, seizures, dementia, TIA, COPD, hypotension, arthritis, etc.) x. Psychological issues (anxiety, agitation, depression, failure to thrive, etc.) y. Cognitive status (alert, oriented, confused, varies, change in the last 30 days, etc.) z. Change in sleep patterns? If so, explain. aa. Judgement (poor safety awareness, good judgement, varies, makes needs known, unable) bb. Behavior/Mood problems (sundowning, wandering, agitation, hallucinations, combative, etc.) cc. Notification to LAW ENFORCEMENT (Date/Time). What was their response. dd. Notification to FAMILY (Date/Time). What was their response. ee. Notification to PRIMARY CARE PROVIDER/MD (Date/Time). What was their response. ff. Notification to NURSING ASSISTANT REGISTRY/BOARD OF NURSING? gg. Notification of OMBUDSMAN. What was their response? hh. Was the victim (resident) sent to the hospital for evaluation? Document Where, When, Date and Time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25 identified she had moderate cognitive impairment with diagnoses of muscle weakness, pain, anxiety and depression. No cognitive affecting diagnoses were identified. R1 required a 2 staff assist with bed mobility, transfers, dressing and toilet use and locomotion with the use of a wheelchair. R1's nursing assessments identified there was no skin or other assessment performed since 2/12/21 to identify staff had performed a full inspection of R1 to ensure she was not injured from the rough cares. Observation and interview on 3/23/21 at 2: 44 p.m. identified R1 stated she couldn't recall the event. "I don't remember it" and stated repeatedly she didn't know anything regarding the care received on 3/17. R1 appeared hesitant to speak and would not make eye contact once asked about the allegation. When asked if she knew who she could report an abusive situation to, she replied she did not know. R1 stated she currently felt safe at the facility. R1 had no bruising or marks to indicate injuries visible at the time of the interview. R1 was alert to person, place and time and noted to be an accurate historian. R1's 3/19/21, physician (MD) visit note identified R1 was doing well and staff were concerned over a UTI. R1 reported pain in all of her extremeties. There was no mention R1 reported the rough cares by NA-C to MD-A. R1's progress notes identified on: 1) 3/17/21, there is no indication staff assessed R1 for potential injuries from allegations of abuse. 2) 3/19/21, staff noted R1's urinary culture report identified she mixed bacterium, however MD-A declined to treat it at that time. There was no	F 609	On 3/24/2021, education was provided for staff in all departments that addresses staff burnout and how to identify if a staff member is showing signs of burnout and the steps to report this to the supervisor. Following this education, supervisors were further trained on 03/30/2021, during department manager meeting, educating them on the steps to take if an employee under their supervision is experiencing burnout. All staff completed this training on 03/30/2021. To help reduce staff burnout, the Director of Nursing and Administrator have been in contact with annLeo and All Temporaries for assistance with staffing to help with staff burnout. They notified us that they did have someone that could potentially help us out. However, this person previously worked for us, was terminated and is on a no-rehire status. Administrator and Director of Nursing felt that this was not an adequate solution and asked the pool agency to find others. They were able to provide two individuals to provide minimal coverage of a couple of shifts to-date, so the Administrator initiated new contracts with KareKrest, Prime Time Healthcare and Nurzee; they are in the process of locating pool staffing to help give our staff a break to help with burnout. All-staff education and training is scheduled for April 19, 20, and 21 providing all employees the required annual facility specific Abuse, Neglect,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 26 indication staff identified R1's additional bathroom requests as potential signs of a bladder infection. Interview on 3/23/21 at 2:54 p.m. with LPN-B identified she had not worked last week, but was aware of the allegations made towards NA-C. LPN-B identified NA-C showed signs of burnout."I could see she has been tired". NA-C was arriving for work around 9:00 p.m. to 10:30 p.m. and staying late in the mornings to assist with morning cares. NA-C was getting "lots of overtime". If she sees signs of burnout in staff, she tells them to "Go take a breather". She had told NA_C to take those additional breaks before. LPN-B acknowledged she had not advised the director of nursing (DON) of her concerns or observations of staff burnout. Interview on 3/23/21 at 3:04 p.m. with NA-C identified she worked until 11:08 a.m. that morning as there was no additional staff to do resident baths. NA-C has worked at the facility for 3 years. NA-C stated R1 had used her call light several times that night but denied the allegations of verbal and physical abuse. NA-C specifically stated she was by R1's feet and not her head as she had already finished washing the top half of R1's body. "I honestly don't remember her hitting her head. I always adjust her pillow". NA-C denied feeling tired and stated she de-stresses appropriately. NA-C was suspended pending the investigation and was terminated. Review of NA-C's employee file identified she was disciplined in September of 2019 for insubordination to the charge nurse. NA-C was reprimanded for not answering a call light and eating at the nurses station during her overnight shift. The LPN directed her to answer the call	F 609	Mistreatment, Misappropriation of Resident Property and Exploitation Policy and Procedures using the updated 2017 LeadingAge and Pathway Health edition of this policy and procedure, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedure. Zero Tolerance of Retaliation Policy Here at Gil-Mor, we will not tolerate intimidation or retaliation against anyone who raises a concern, makes a report, or cooperates in an investigation. Retaliation is not just malicious and contrary to our core values; it also undermines the culture of openness and trust we are determined to maintain. Any threat of retaliation can hinder investigations and prevent people from coming forward with concerns. Retaliation can take many forms and is sometimes subtle. It can also occur inside or outside of the workplace. In many instances, it is also illegal. Each of us has a role to play in making retaliation unacceptable and maintaining an environment in which we can all feel safe and comfortable raising an issue or reporting a violation. We recognize speaking up is not easy, however, at Gil-Mor, we want to make the decision to speak up and report concerns as simple as possible. Retaliation against anyone who raises a concern or reports a violation in good faith may result in disciplinary action, up to and including termination of employment. For all newly hired employees, our Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 27 light. NA-C got up, slammed her chair against the desk and stormed past the nurse. Interview on 3/23/21 at 4:37 p.m. with the DON identified NA-D had reported the incident to her at approximately 1:30 p.m. or so, just as she was getting ready to leave. The DOn had to come back to work in a few hours to cover the evening shift and advised NA-D to report the incident to the administrator. When she returned at 3:30, the administrator advised her the incident required reporting. She started her investigation and then filed the report about an hour later. Staff had abuse training online yearly but were not trained to facility abuse policies specifically. No staff were re-educated after the incident. The DOn spoke with NA-A, NA-C and NA-D. The DON was unsure how to proceed after the allegation was made as this was the first time anything like this had happened at the facility. R1's physician, MD-A is also the medical director. He and family were made aware of the incident after she reported it to the SA. The family reported R1 stated to them she was surprised her glasses weren't broke as her head hit hard. The DON agreed no formal assessment occurred immediately after the allegation was made to identify if R1 had any injuries. "I did inspect her face" when she spoke to R1, but did not do or delegate a formal assessment for injuries for R1. The DON was unaware of how to monitor staff for burnout. There was no policy she was aware of for that. The DON stated all staff are over worked related to the pandemic. The facility does have a contract for pool staff, but the workers are unreliable so they do not use them often at all. They advertise for help in the paper. The facility just had annual inservices, but abuse was not discussed as they focused on the pandemic	F 609	Development-RN will ensure that all new employees receive training on our facility specific Abuse and Neglect policy and procedures, they will receive a copy of the Abuse and Neglect packet that includes the quiz to test their knowledge and understanding. Also, SD-RN will ensure that new hires understand and are competent and stress the importance of understanding that every employee is a mandated reporter and there is a zero tolerance of retaliation policy. If abuse is suspected it must be REPORTED IMMEDIATELY to the Charge Nurse, Administrator and DON, keeping the resident safe and removing them from danger immediately. In the event abuse or neglect is reported to the charge nurse, the charge nurse will follow chain of command and report it immediately to the Administrator and Director of Nursing. The Administrator and DON is responsible for reporting the incident within 2 hours of notification to the State Agency/OHFC and completion of the follow-up investigation within 5 days. On 03/24/2021, all employees were given an educational packet titled Job Burnout: How to spot it and take action. We then tested their knowledge and understanding by having each employee complete the Burnout Quiz. Included in this information was who to contact and how to ask for help, additional steps to take to de-stress, and provided additional methods for stress management. Then on 03/30/2021, all supervisors received additional Burnout education and training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 28 needs. Staff were trained online yearly in a generalized training. The DON indicated she suspected the allegation to be true and had terminated NA-C's employment. The DON had not reported her findings to law enforcement or the nurse aide registry. She was unaware the facility policies had not been reviewed yearly as required by federal regulation. She agreed facility policy had not been followed at the time of the incident related to reporting, keeping the resident safe, and investigation. Interview and document review on 3/24/21 at 11:39 a.m. with MD-A identified he was made aware of the allegations. He was unsure what interventions staff placed for R1's safety. He agreed burnout was a likely cause of the abuse. He was unaware the facility had no policy, plan, or procedure related to staff burnout and was unaware staff were not specifically trained to facility abuse policies. He agreed the facility failed to follow their abuse policies as identified below. Review of the 1/9/14, Vulnerable Adult policy identified any suspected abuse, neglect, or mistreatment was to be reported immediately to the charge nurse, who was to then notify the administrator and DON immediately after becoming aware of the allegation. Abuse was defined as conduct which was not an accident that produces or could produce pain, injury or emotional distress. The administrator or designee was to report the incident to the SA. In cases of abuse where there was a potential for harm , staff were to take immediate steps to protect the resident. The administrator or designee was to interview victims, employees, witnesses, family members, visitors, etc.	F 609	on how to identify any indicators, signs and symptoms of their employees suffering from burnout. Our Staff Development-RN provided all employees educational and information on stress management that identified different places and methods to help relieve stress. Below is information regarding stress management and methods of relaxation, provided over the past year to employees. "5/5/2020 Mental Health and Psyco-social considerations during COVID-19 "5/15/2020 Free information provided from Dr. Samantha Peterson, Psychologist; American Red Cross Supporting yourself and others during COVID-19, University of Toronto - Mind Control: Managing Your Mental Health During COVID-19, Beck Institute (Beck Cognitive Behavioral Therapy) Managing Mental Health in the Workplace, 10 Virtual Therapy and Mental Health Apps to Cope with Coronavirus Stress, CBT for Front-line Medical Professionals: Brief Interventions during a time of crisis, CBT Substance Use Disorders during the COVID-19 Crisis (2-part series) "01/11/2021 Statewide Healthcare Coordination Center□s Behavioral Health Staff Wellness Group Reaching for a Calm 21 Brown Bag Series "01/25/2021 Offered two links on videos to help you relax "01/25/2021 through 01/29/2021 Gil-Mor set-up a Relaxation Room for staff to show examples of how aromatherapy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 29 Review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified abuse was defined as intentional mistreatment that could or did result in physical pain, injury and causes or reasonably expected to cause mental or emotional damage to the resident. All new employees were to be oriented to the Resident Protection Plan and made aware of their responsibility to report any suspected maltreatment as defined and described in this plan. Yearly inservices on the facility abuse policy was mandatory for all employees. The policy was to be posted in a conspicuous location in the facility. All reports of suspected crimes or abuse were to be reported immediately to law enforcement to be investigated. Immediately upon receiving a report, nursing staff were to remove the resident from the situation./ Employees were to be immediately removed from the facility pending investigation. and staff were to examine, assess and interview the resident to determine injury. There was to be no retaliation for an employee who makes a report. Further review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified results of the investigation were to be reported within 5 days to the SA and was to include: 1) Name and age of resident 2) Cognitive level 3) description of the incident 4) date and time of incident 5) Where it took place. 6) type and location of injuries of any. 7) Name of person who discovered/observed the incident 8) Name of person incident reported to.	F 609	a relaxation video. Provided Relaxation and Rest information that described how getting 8 hours of sleep every night is best for good health, your immune system works better if you relax and unwind, and while adrenalin, norepinephrine and cortisol are released when a person does physical activity, these are healthy levels. When you are constantly stressed, these hormones are still released and increases the risk of developing heart disease. These hormones can start affecting your ability to sleep. The immune system loses the inflammation phase of healing when cortisol is in high levels in your blood this is one of the necessary phases of healing for our immune system "On 03/01/2021, all staff received a survey to complete to help our facility management staff identify areas needing attention or improvement. Survey questions were as follows: o What do you enjoy about working at Gil-Mor? o What do you feel is the most difficult part of your job here at Gil-Mor? o What changes would make things better for you in the work environment? o What do feel empowers you to continue to work as a Gil-Mor employee? o What could Gil-Mor do more of or better to help you feel empowered? o Would you be interested in becoming a mentor for new staff? "On 3/24/2021 Educational information called Job Burnout: How to spot it and take action, as well as testing employees knowledge and understanding through the Burnout quiz.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 30 9) Names of people outside the facility who were notified including police, physicians, family members. Substantiated complaints against other employees were to be reported to the respective boards. Review of the undated Incident Report Guide identified after an allegation of abuse was made, staff were to protect the resident first. Next, they were to interview the alleged perpetrator (AP). Staff were to assess the resident and document findings. All staff were to be interviewed, and reports to the SA and law enforcement were to be made.	F 609	"On 03/30/2021 Additional Burnout education and training was provided to all Department Managers to help them identify any indicators, signs and symptoms of their employees suffering from burnout. On an annual basis, the Staff Development-RN will be responsible for setting up in-service meetings to offer all annually required education and training as required by our state and federal licensure such as our facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, Vulnerable Adult, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedures. As of 03/24/2021 and ongoing the Staff Development-RN will be responsible for all new hire education and training and will ensure that all new hires receive all required training for our state and federal licensure. This plan of correction includes the following education topics and training to test their knowledge and understanding of each topic: - Vulnerable Adult - Facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property - Abuse Prevention - Mandatory reporting and Zero Tolerance of Retaliation All newly hired employee personnel files will be audited by the Director of Nursing/Supervisor or designee to ensure that all education and training above has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 31	F 609	been completed and a quarterly report will be submitted to the quarterly Quality Assurance Committee for review. The Gil-Mor facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy and Procedures are prominently posted for all residents on the dining room bulletin board and for all employees in the employee break room and on the employee bulletin board located by the timeclock. During the QA meeting held on April 23, 2021, we discussed our plan of correction and felt that it is necessary to expand our audit review to ensure that our residents are free from Abuse, Neglect, Mistreatment and Misappropriation of Resident Property. All incident reports and psychosocial resident interviews that are completed for each residents Care Conference will be audited by the Director of Nursing or designee and the results will be presented to the management team during their weekly management meetings. This audit will be conducted based on the resident□s answers to the following key interview questions such as, 1. How does staff treat you and/or resident? 2. Do you feel safe here and are you treated in a dignified manner? 3. Have you ever been treated roughly? 4. Do you get enough private time (privacy)? 5. Is there anything we could do to help you be as active as you want to be?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 32	F 609	6. Do you or your family have any goals for care or stay here at Gil-Mor? 7. Have you ever felt that your rights have been violated? Then on a monthly basis, the Administrator or designee will review these audit findings to ensure timely reporting, thorough resident assessment and investigation has been done to ensure residents safety. The format of the audit summary will include a list of the number of audited incident reports and psychosocial interviews in order to ensure that we are preventing abuse and neglect and to determine our compliance of timely reporting of abuse, neglect, mistreatment and misappropriation of resident property, ensure proper investigation and ensure resident safety. This audit summary report will be submitted quarterly to the quarterly Quality Assurance meetings for further review and recommendations. The completion date for correction of this deficiency is 04/23/2021.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		4/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 33 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to thoroughly investigate an allegation of physical and verbal abuse for 1 of 1 resident (R1). Findings include: Review of the 3/17/21 4:39 p.m., report to the State Agency (SA) identified NA-A and NA-C were providing morning cares to R1. While turning R1 from side to side, R1 was handled roughly causing her head to get bumped into her side rail 4 times. R1 stated several times, her head to hurt and asked for a different care giver. R1 asked NA-C why she was so mean to her. NA-C reportedly replied "That's what you get for being a [expletive] all night". NA-C was suspended pending the investigation. Review of the 3/19/21, 5 day investigation report submitted to the SA identified the facility indicated staff failed to remove R1 from a potentially dangerous situation. NA-C was terminated. All staff were to be trained annually to abuse policies. No changes were needed to the policy or procedure. Facility interview with: 1) NA-A identified she felt NA-C had an irritated disposition that day as R1 had been on the bed pan several times during the night. NA-C was	F 610	The Director of Nursing reviewed our facility policies and procedures with Administrator and the DON developed a new Progress Note titled Abuse/Neglect Incident Report in PointClickCare to ensure that ALL parts of the report and investigation are completed, and that reporting is done within 2 hours of incident occurring. This report method is currently being used for other types of incidents such as falls, and skin injuries; which has been an effective tool that walks staff step-by-step through the initial report. This incident report method will ensure that staff are guided through the entire process from the initial report all the way through the investigation to ensure proper handling of each incident. 1. Did you ensure that the resident was safe, removed from harm, protected from harm? Explain. 2. NOTIFICATION IMMEDIATELY: Administrator, document date and time. 3. Remove alleged perpetrator and place employee on suspension until investigation. 4. Was this reported to OHFC (SA) within 2 hours of initial report? Explain. 5. NOTIFICATION: Director of Nursing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 34 "red hot" when she and NA-A entered R1's room prior to the incident. NA-A was by R1's feet and NA-C was by R1's head. When R1 was rolled to her left side her head was "rammed" into the side rail. Each time R1 was rolled to the side her head was bumped into the rail. NA-C advised NA-A she was "sick of dealing" with R1. There was no indication NA-A stopped the rough treatment and intervened to ensure the rough handling and verbal abuse stopped after the first time her head was struck into the rail. NA-A was afraid of retaliation from NA-C. NA-A assisted R1 the next day with her morning cares. R1 complained her head still hurt from the day before. 2) R1 identified she had not wanted to get NA-C in trouble when asked about the incident. R1 advised staff she was worried her glasses were bent after hitting the rail. R1 would not say if she felt NA-C was intentional in her actions, but did state "Well, i know she doesn't like me". R1 was assessed by the DON during her interview, and did say she had pain in her face 3 out of 10. No visible bruising was noted. 3) NA-C identified R1 used her call light several times that night, questioning why she wasn't fed, and thinking she was eating in her bed. In the morning, NA-C put R1 on the bed pan. R1 often leaned to her left side so she moves the resident to her right side to ensure she doesn't bump her head on her rail. NA-C called for NA-A to assist her getting R1 off her bedpan. NA-C made a point to advise NA-A to move the resident to her right side so she would not bump her hear or face on the rail. NA-A denied R1 ever hit her head and denied making the verbally abuse comment to R1. NA_C had been staying longer in the mornings as the facility was short staffed. NA-C identified R1 had asked her "Why do you hate me?" during the night and reassured R1 she did	F 610	document date and time. 6. Begin investigation IMMEDIATELY after notifying Administrator and DON. Yes/No a. Interview the initial reporter □ use interview sheets in Abuse/Neglect Binder. Yes/No b. Interview the victim (resident) - use interview sheets in Abuse/Neglect Binder. Yes/No c. Interview other residents □ use interview sheets in Abuse/Neglect Binder. Yes/No d. Interview other staff that may have witnessed the incident or other similar incidents - use the interview sheets in Abuse/Neglect Binder. Yes/No e. Interview any witnesses □ use the interview sheets in Abuse/Neglect Binder. Yes/No f. All interviews should have direct statements in quotes. Yes/No g. Interview Visitors, Family members that may have information. Yes/No h. Location of incident. i. Explain exactly what was reported by the INITIAL REPORTER □ direct statements should be in quotations. j. Were there witnesses? If so, Who? k. Explain exactly what was reported by the WITNESS/WITNESSES □ direct statements should be in quotations. l. Explain exactly what was reported by the VICTIM(RESIDENT) □ direct statements should be in quotations. m. Explain exactly what was reported by OTHER RESIDENTS □ statements should be in quotations. n. Explain exactly what was reported by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 35 not. There was no indication staff had immediately assessed R1 head-to-toe that same morning to ensure she was not bruised elsewhere on her body from the rough cares, no indication other staff or residents were interviewed, or re-trained to facility policies. Interview on 3/23/21 at 1:34 p.m., with NA-A identified she was a NA trainee. The event occurred on 3/17/21 at approximately 9:00 a.m.. NA-A and NA-C went into R1's room. NA-A was by R1's feet and NA-C was by her head. "Every time we rolled her, [R1] hit her face on the grab bar" which was to R1's left side. R1 asked NA-C why she was so mean. NA-C replied "That's what you get for being a [expletive] all night". R1 asked for a different care giver. R1 was very distraught. Even after the incident, R1 refused to take a bath, and would not eat breakfast. She was "Very upset and teary eyed". When NA-A and NA-C left R1's room, NA-C said she was "Sick of [R1]". NA-A told another co-worker (NA-D) of the incident about 45 minutes after it occurred as NA-A wasn't sure what to do. NA-A had no retraining to facility abuse policies after the incident. The next day, NA-A and NA-B were assisting R1. R1 made the comment to "please not run my head into the bar." During morning stand-up, the overnight nurse, licensed practical nurse (LPN)-A had asked in morning report "Who tattled?!" when discussing the allegations of abuse against NA-C. NA-A felt very intimidated by LPN-A's remark. The facility just had annual training at inservices, but abuse was not covered. Interview on 3/23/21 with NA-B identified she assisted NA-A in R1's morning cares that R1 made the comment her head hurt because of	F 610	VISITORS, FAMILY MEMBERS □ statements should be in quotations. o. Explain exactly what was reported by OTHER STAFF □ statements should be in quotations. p. What type of abuse occurred? (physical, verbal, sexual, emotional, neglect, financial exploitation) q. Did the incident cause injury? Explain. r. Did a licensed nurse complete a full body assessment on the victim (resident)? s. Vital signs of the victim (resident). t. Routine medications (cardio, diuretics, narcotics, PRN meds, laxatives, diabetic, Parkinson□s, etc.). u. Psychoactive medications (antipsychotics, antianxiety, hypnotics, routine, PRN, antidepressants, etc.) v. Acute changes (UTI, syncope, weight loss, fever, URI, delirium, other infection). w. Chronic conditions (CVA, Parkinson□s, seizures, dementia, TIA, COPD, hypotension, arthritis, etc.) x. Psychological issues (anxiety, agitation, depression, failure to thrive, etc.) y. Cognitive status (alert, oriented, confused, varies, change in the last 30 days, etc.) z. Change in sleep patterns? If so, explain. aa. Judgement (poor safety awareness, good judgement, varies, makes needs known, unable) bb. Behavior/Mood problems (sundowning, wandering, agitation, hallucinations, combative, etc.) cc. Notification to LAW ENFORCEMENT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 36 NA-C "pushing her head into the rail". NA-B had only worked with NA-C one other time. NA-C worked overnights. NA-B also witnessed LPN-A "yell" and "be mad" staff and asked staff in report "Who tattled?!" NA-B fears retaliation form other staff for reporting incidents. "If we dos something, one person will be mad" at them. NA-B was not spoken to by the DON during the investigation, and no re-education on abuse occurred after the incident. R1's 2/12/21, quarterly Minimum Data Set (MDS) identified she had moderate cognitive impairment with diagnoses of muscle weakness, pain, anxiety and depression. No cognitive affecting diagnoses were identified. R1 required a 2 staff assist with bed mobility, transfers, dressing and toilet use and locomotion with the use of a wheelchair. R1's nursing assessments identified there was no skin or other assessment performed since 2/12/21 to identify staff had performed a full inspection of R1 to ensure she was not injured from the rough cares. Observation and interview on 3/23/21 at 2: 44 p.m. identified R1 stated she couldn't recall the event. "I don't remember it" and stated repeatedly she didn't know anything regarding the care received on 3/17. R1 appeared hesitant to speak and would not make eye contact once asked about the allegation. When asked if she knew who she could report an abusive situation to, she replied she did not know. R1 stated she currently felt safe at the facility. R1 had no bruising or marks to indicate injuries visible at the time of the interview. R1 was alert to person, place and time and noted to be an accurate historian.	F 610	(Date/Time). What was their response. dd. Notification to FAMILY (Date/Time). What was their response. ee. Notification to PRIMARY CARE PROVIDER/MD (Date/Time). What was their response. ff. Notification to NURSING ASSISTANT REGISTRY/BOARD OF NURSING? gg. Notification of OMBUDSMAN. What was their response? hh. Was the victim (resident) sent to the hospital for evaluation? Document Where, When, Date and Time. On 3/24/2021, education was provided for staff in all departments that addresses staff burnout and how to identify if a staff member is showing signs of burnout and the steps to report this to the supervisor. Following this education, supervisors were further trained on 03/30/2021, during department manager meeting, educating them on the steps to take if an employee under their supervision is experiencing burnout. All staff completed this training on 03/30/2021. To help reduce staff burnout, the Director of Nursing and Administrator have been in contact with annLeo and All Temporaries for assistance with staffing to help with staff burnout. They notified us that they did have someone that could potentially help us out. However, this person previously worked for us, was terminated and is on a no-rehire status. Administrator and Director of Nursing felt that this was not an adequate solution and asked the pool agency to find others.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 37 R1's 3/19/21, physician (MD) visit note identified R1 was doing well and staff were concerned over a UTI. R1 reported pain in all of her extremeties. There was no mention R1 reported the rough cares by NA-C to MD-A. R1's progress notes identified on: 1) 3/17/21, there is no indication staff assessed R1 for potential injuries from allegations of abuse. 2) 3/19/21, staff noted R1's urinary culture report identified she mixed bacterium, however MD-A declined to treat it at that time. There was no indication staff identified R1's additional bathroom requests as potential signs of a bladder infection. Interview on 3/23/21 at 2:54 p.m. with LPN-B identified she had not worked last week, but was aware of the allegations made towards NA-C. LPN-B identified NA-C showed signs of burnout."I could see she has been tired". NA-C was arriving for work around 9:00 p.m. to 10:30 p.m. and staying late in the mornings to assist with morning cares. NA-C was getting "lots of overtime". If she sees signs of burnout in staff, she tells them to "Go take a breather". She had told NA_C to take those additional breaks before. LPN-B acknowledged she had not advised the director of nursing (DON) of her concerns or observations of staff burnout. Interview on 3/23/21 at 3:04 p.m. with NA-C identified she worked until 11:08 a.m. that morning as there was no additional staff to do resident baths. NA-C has worked at the facility for 3 years. NA-C stated R1 had used her call light several times that night but denied the allegations of verbal and physical abuse. NA-C specifically stated she was by R1's feet and not her head as she had already finished washing the top half of	F 610	They were able to provide two individuals to provide minimal coverage of a couple of shifts to-date, so the Administrator initiated new contracts with KareKrest, Prime Time Healthcare and Nurzee; they are in the process of locating pool staffing to help give our staff a break to help with burnout. All-staff education and training is scheduled for April 19, 20, and 21 providing all employees the required annual facility specific Abuse, Neglect, Mistreatment, Misappropriation of Resident Property and Exploitation Policy and Procedures using the updated 2017 LeadingAge and Pathway Health edition of this policy and procedure, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedure. Zero Tolerance of Retaliation Policy Here at Gil-Mor, we will not tolerate intimidation or retaliation against anyone who raises a concern, makes a report, or cooperates in an investigation. Retaliation is not just malicious and contrary to our core values; it also undermines the culture of openness and trust we are determined to maintain. Any threat of retaliation can hinder investigations and prevent people from coming forward with concerns. Retaliation can take many forms and is sometimes subtle. It can also occur inside or outside of the workplace. In many instances, it is also illegal. Each of us has a role to play in making retaliation unacceptable and maintaining an environment in which we	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 38 R1's body. "I honestly don't remember her hitting her head. I always adjust her pillow". NA-C denied feeling tired and stated she de-stresses appropriately. NA-C was suspended pending the investigation and was terminated. Review of NA-C's employee file identified she was disciplined in September of 2019 for insubordination to the charge nurse. NA-C was reprimanded for not answering a call light and eating at the nurses station during her overnight shift. The LPN directed her to answer the call light. NA-C got up, slammed her chair against the desk and stormed past the nurse. Interview on 3/23/21 at 4:37 p.m. with the DON identified NA-D had reported the incident to her at approximately 1:30 p.m. or so, just as she was getting ready to leave. The DOn had to come back to work in a few hours to cover the evening shift and advised NA-D to report the incident to the administrator. When she returned at 3:30, the administrator advised her the incident required reporting. She started her investigation and then filed the report about an hour later. Staff had abuse training online yearly but were not trained to facility abuse policies specifically. No staff were re-educated after the incident. The DOn spoke with NA-A, NA-C and NA-D. The DON was unsure how to proceed after the allegation was made as this was the first time anything like this had happened at the facility. R1's physician, MD-A is also the medical director. He and family were made aware of the incident after she reported it to the SA. The family reported R1 stated to them she was surprised her glasses weren't broke as her head hit hard. The DON agreed no formal assessment occurred immediately after the allegation was made to	F 610	can all feel safe and comfortable raising an issue or reporting a violation. We recognize speaking up is not easy, however, at Gil-Mor, we want to make the decision to speak up and report concerns as simple as possible. Retaliation against anyone who raises a concern or reports a violation in good faith may result in disciplinary action, up to and including termination of employment. For all newly hired employees, our Staff Development-RN will ensure that all new employees receive training on our facility specific Abuse and Neglect policy and procedures, they will receive a copy of the Abuse and Neglect packet that includes the quiz to test their knowledge and understanding. Also, SD-RN will ensure that new hires understand and are competent and stress the importance of understanding that every employee is a mandated reporter and there is a zero tolerance of retaliation policy. If abuse is suspected it must be REPORTED IMMEDIATELY to the Charge Nurse, Administrator and DON, keeping the resident safe and removing them from danger immediately. In the event abuse or neglect is reported to the charge nurse, the charge nurse will follow chain of command and report it immediately to the Administrator and Director of Nursing. The Administrator and DON is responsible for reporting the incident within 2 hours of notification to the State Agency/OHFC and completion of the follow-up investigation within 5 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 39 identify if R1 had any injuries. "I did inspect her face" when she spoke to R1, but did not do or delegate a formal assessment for injuries for R1. The DON was unaware of how to monitor staff for burnout. There was no policy she was aware of for that. The DON stated all staff are over worked related to the pandemic. The facility does have a contract for pool staff, but the workers are unreliable so they do not use them often at all. They advertise for help in the paper. The facility just had annual inservices, but abuse was not discussed as they focused on the pandemic needs. Staff were trained online yearly in a generalized training. The DON indicated she suspected the allegation to be true and had terminated NA-C's employment. The DON had not reported her findings to law enforcement or the nurse aide registry. She was unaware the facility policies had not been reviewed yearly as required by federal regulation. She agreed facility policy had not been followed at the time of the incident related to reporting, keeping the resident safe, and investigation. Interview and document review on 3/24/21 at 11:39 a.m. with MD-A identified he was made aware of the allegations. He was unsure what interventions staff placed for R1's safety. He agreed burnout was a likely cause of the abuse. He was unaware the facility had no policy, plan, or procedure related to staff burnout and was unaware staff were not specifically trained to facility abuse policies. He agreed the facility failed to follow their abuse policies as identified below. Review of the 1/9/14, Vulnerable Adult policy identified any suspected abuse, neglect, or mistreatment was to be reported immediately to the charge nurse, who was to then notify the	F 610	On 03/24/2021, all employees were given an educational packet titled Job Burnout: How to spot it and take action. We then tested their knowledge and understanding by having each employee complete the Burnout Quiz. Included in this information was who to contact and how to ask for help, additional steps to take to de-stress, and provided additional methods for stress management. Then on 03/30/2021, all supervisors received additional Burnout education and training on how to identify any indicators, signs and symptoms of their employees suffering from burnout. Our Staff Development-RN provided all employees educational and information on stress management that identified different places and methods to help relieve stress. Below is information regarding stress management and methods of relaxation, provided over the past year to employees. "5/5/2020 Mental Health and Psyco-social considerations during COVID-19 "5/15/2020 Free information provided from Dr. Samantha Peterson, Psychologist; American Red Cross □ Supporting yourself and others during COVID-19, University of Toronto - Mind Control: Managing Your Mental Health During COVID-19, Beck Institute (Beck Cognitive Behavioral Therapy) □ Managing Mental Health in the Workplace, 10 Virtual Therapy and Mental Health Apps to Cope with Coronavirus Stress, CBT for Front-line Medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 40 administrator and DON immediately after becoming aware of the allegation. Abuse was defined as conduct which was not an accident that produces or could produce pain, injury or emotional distress. The administrator or designee was to report the incident to the SA. In cases of abuse where there was a potential for harm , staff were to take immediate steps to protect the resident. The administrator or designee was to interview victims, employees, witnesses, family members, visitors, etc. Review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy identified abuse was defined as intentional mistreatment that could or did result in physical pain, injury and causes or reasonably expected to cause mental or emotional damage to the resident. All new employees were to be oriented to the Resident Protection Plan and made aware of their responsibility to report any suspected maltreatment as defined and described in this plan. Yearly inservices on the facility abuse policy was mandatory for all employees. The policy was to be posted in a conspicuous location in the facility. All reports of suspected crimes or abuse were to be reported immediately to law enforcement to be investigated. Immediately upon receiving a report, nursing staff were to remove the resident from the situation./ Employees were to be immediately removed from the facility pending investigation. and staff were to examine, assess and interview the resident to determine injury. There was to be no retaliation for an employee who makes a report. Further review of the 2015, Abuse, Neglect, Mistreatment and Misappropriation of Resident	F 610	Professionals: Brief Interventions during a time of crisis, CBT Substance Use Disorders during the COVID-19 Crisis (2-part series) "01/11/2021 Statewide Healthcare Coordination Center□s Behavioral Health Staff Wellness Group Reaching for a Calm 21 Brown Bag Series "01/25/2021 Offered two links on videos to help you relax "01/25/2021 through 01/29/2021 Gil-Mor set-up a Relaxation Room for staff to show examples of how aromatherapy and a relaxation video. Provided Relaxation and Rest information that described how getting 8 hours of sleep every night is best for good health, your immune system works better if you relax and unwind, and while adrenalin, norepinephrine and cortisol are released when a person does physical activity, these are healthy levels. When you are constantly stressed, these hormones are still released and increases the risk of developing heart disease. These hormones can start affecting your ability to sleep. The immune system loses the inflammation phase of healing when cortisol is in high levels in your blood this is one of the necessary phases of healing for our immune system "On 03/01/2021, all staff received a survey to complete to help our facility management staff identify areas needing attention or improvement. Survey questions were as follows: o What do you enjoy about working at Gil-Mor? o What do you feel is the most difficult part of your job here at Gil-Mor?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 41 Property policy identified results of the investigation were to be reported within 5 days to the SA and was to include: 1) Name and age of resident 2) Cognitive level 3) description of the incident 4) date and time of incident 5) Where it took place. 6) type and location of injuries of any. 7) Name of person who discovered/observed the incident 8) Name of person incident reported to. 9) Names of people outside the facility who were notified including police, physicians, family members. Substantiated complaints against other employees were to be reported to the respective boards. Review of the undated Incident Report Guide identified after an allegation of abuse was made, staff were to protect the resident first. Next, they were to interview the alleged perpetrator (AP). Staff were to assess the resident and document findings. All staff were to be interviewed, and reports to the SA and law enforcement were to be made.	F 610	o What changes would make things better for you in the work environment? o What do feel empowers you to continue to work as a Gil-Mor employee? o What could Gil-Mor do more of or better to help you feel empowered? o Would you be interested in becoming a mentor for new staff? "On 3/24/2021 Educational information called Job Burnout: How to spot it and take action, as well as testing employees□ knowledge and understanding through the Burnout quiz. "On 03/30/2021 Additional Burnout education and training was provided to all Department Managers to help them identify any indicators, signs and symptoms of their employees suffering from burnout. On an annual basis, the Staff Development-RN will be responsible for setting up in-service meetings to offer all annually required education and training as required by our state and federal licensure such as our facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, Vulnerable Adult, Mandated Reporter and Zero Tolerance of Retaliation Policy and Procedures. As of 03/24/2021 and ongoing the Staff Development-RN will be responsible for all new hire education and training and will ensure that all new hires receive all required training for our state and federal licensure. This plan of correction includes the following education topics and training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 42	F 610	to test their knowledge and understanding of each topic: - Vulnerable Adult - Facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property - Abuse Prevention - Mandatory reporting and Zero Tolerance of Retaliation All newly hired employee personnel files will be audited by the Director of Nursing/Supervisor or designee to ensure that all education and training above has been completed and a quarterly report will be submitted to the quarterly Quality Assurance Committee for review. The Gil-Mor facility specific Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy and Procedures are prominently posted for all residents on the dining room bulletin board and for all employees in the employee break room and on the employee bulletin board located by the timeclock. During the QA meeting held on April 23, 2021, we discussed our plan of correction and felt that it is necessary to expand our audit review to ensure that our residents are free from Abuse, Neglect, Mistreatment and Misappropriation of Resident Property. All incident reports and psychosocial resident interviews that are completed for each residents Care Conference will be audited by the Director of Nursing or designee and the results will be presented to the management team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 03/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 43	F 610	during their weekly management meetings. This audit will be conducted based on the resident□s answers to the following key interview questions such as, 1. How does staff treat you and/or resident? 2. Do you feel safe here and are you treated in a dignified manner? 3. Have you ever been treated roughly? 4. Do you get enough private time (privacy)? 5. Is there anything we could do to help you be as active as you want to be? 6. Do you or your family have any goals for care or stay here at Gil-Mor? 7. Have you ever felt that your rights have been violated? Then on a monthly basis, the Administrator or designee will review these audit findings to ensure timely reporting, thorough resident assessment and investigation has been done to ensure residents safety. The format of the audit summary will include a list of the number of audited incident reports and psychosocial interviews in order to ensure that we are preventing abuse and neglect and to determine our compliance of timely reporting of abuse, neglect, mistreatment and misappropriation of resident property, ensure proper investigation and ensure resident safety. This audit summary report will be submitted quarterly to the quarterly Quality Assurance meetings for further review and recommendations. The completion date for correction of this deficiency is 04/23/2021.	