Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 30, 2026

Administrator
Gil-Mor Manor
96 THIRD STREET EAST
MORGAN, MN 56266

RE: CCN: 245594
Cycle Start Date: December 16, 2025

Dear Administrator:

On December 16, 2025, the Minnesota Department(s) of Health and Public Safety, 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 30, 2026

Administrator
Gil-Mor Manor
96 THIRD STREET EAST
MORGAN, MN 56266

Re: Reinspection Results
Event ID: 1D7F1E-H2

Dear Administrator:

On January 21, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 16, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 16, 2025

Administrator
Gil-Mor Manor

96 THIRD STREET EAST
MORGAN, MN 56266

RE: CCN: 245594
Cycle Start Date: December 16, 2025

Dear Administrator:

On December 16, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

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

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 March 16, 2026(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 June 16, 2026(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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 16, 2025

Administrator
Gil-Mor Manor
96 THIRD STREET EAST
MORGAN, MN 56266

Re: State Nursing Home Licensing Orders
Event ID: 1D7F1EH1

Dear Administrator:

The above facility survey was completed on December 16, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0000	INITIAL COMMENTS On 09/26/25 and 09/30/25, an 10/1/25 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H55945072C (2624396) with a deficiency issued at F689, F657, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		12/26/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F0657	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal regulations of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. Gil-Mor Manor has and always will ensure that all residents care plans will be reviewed and revised by the interdisciplinary team with fall interventions following falls according to Gil-Mor Manor Policy. R3 Care Plan was reviewed by IDT on 10/1/2025 to verify current fall interventions effectiveness and appropriateness. See Attachment A	12/26/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0657 SS = D	Continued from page 1 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan with fall interventions following falls for 1 of 3 residents (R3) reviewed for falls. Findings include R3's face sheet dated 10/1/25, identified diagnoses of Alzheimer's Disease (a progressive brain leading to memory loss), diabetes mellitus (a condition where the body does not produce enough insulin), and Parkinson's disease (a progressive neurological disorder leading to movement issues). R3's Admission Minimum Data Set (MDS) dated 4/24/25, identified R3 needed moderate assistance for transfers, had two or more falls since admission, and had severe cognitive impairment. R3's fall risk focus care plan dated 4/30/25, identified R3 was high risk for falls related to history of fall and psychoactive drug use. Goal to not sustain serious injury. Interventions were as followed: -call light within reach and encourage to use if for assistance. -ensure wearing appropriate footwear with non-skid soles and gripper socks on at night. -anticipate and meet my needs. -urinal to be kept at bedside during the night. -dycem (anti-slip mat) applied to wheelchair and recliner to help prevent slipping out of my chair.	F0657	Continued from page 1 To ensure that this problem does not recur the Director of Nursing (DON) developed and implemented a Post Fall Review Policy and Procedure on 10/1/2025. This policy includes a monitoring system to ensure individual care plans are revised as necessary. See Attachment B Director of Nursing provided training and education to licensed staff on Fall Documentation and Immediate Intervention Process and proper assessments to be completed with every fall during Annual Skills Fair held on 11/5/2025. See Attachment C To ensure this, audits will be conducted by the Director of Nursing/designee on any falls for timeliness of documentation/assessments/Care Plan updates weekly x4 weeks, then monthly x3 months then randomly to ensure compliance. Audit results will be reported to the QAPI committee to determine ongoing compliance. See Attachment D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0657 SS = D	Continued from page 2 -chair/bed/recliner electronic alarm. Ensure device is in place as needed. -anti-roll backs on wheelchair. -physical therapy to evaluate and treat as needed. -review information on past falls and attempt to determine cause of falls. Record root causes and alter/remove any potential causes if possible. Educate resident/family/caregivers/Interdisciplinary team (IDT) as to causes. R3's fall incident report dated 9/3/25 at 1:15 a.m., identified R3 was found lying on the floor in the dining room where he was sitting in his wheelchair with alarm was attached, however, the alarm did not go off as the string was too long. Immediate action taken was R3 to be placed by the nursing station for monitoring. IDT review done on 9/4/25 identified R3 was impulsive and had confusion, does not make needs known and attempts to self-transfer frequently and if R3 was willing to sit by the nursing station with a tray table for his late-night snack and tab alarms shortened. R3's care plan did not identify an intervention that R3 can sit at nurse's station for a snack utilizing a tray table to staff can keep a closer eye on him until 9/30/25. R3's fall incident report dated 9/6/25 at 4:00 a.m., identified R3's was found on his knees next to his bed on the fall mat and had sustained an abrasion to his right knee. IDT review done on 9/8/25, identified that R3 was compulsive and does not utilize the call light and does not state his needs. 1:1 would be ideal, but not feasible in this setting. Family willing to come and sit with resident when restless and irritable. Continue to toilet and reposition every 2 hours. R3's fall incident report dated 9/6/25 at 4:00 p.m., identified R3's alarm sounded, and he was found on his knees in front of his recliner after his tab alarm sounded. R3 stated he was attempting to get out of his chair and without this thing going off and now you caught me. R3 was taken to the day room and had a good rest of the night. IDT review done on 9/8/25 identified R3 was impulsive and does not utilize the call light and does not make needs known and family to sit with him when restless and agitated. R3 had a medication review done on 9/9/25 and no concerns noted. R3's care plan intervention of family to provide 1:1 when available or needed and to continue to be toileted every 2 hours not revised until 9/29/25 .	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0657 SS = D	Continued from page 3 R3's fall incident report dated 9/7/25 at 7:10 a.m., identified R3's was found on knees in front of his bed. R3 was incontinent at the time for the fall. Other information that R3 attempts to get up unassisted and that the bed alarm was sounding. IDT review done on 9/8/25, identified R3 continues to be impulsive and not utilize the call light to ask for assistance and he strives to be independent when R3 needs assistance. Staff will anticipate R3's needs, offer toileting and repositioning and walks to keep comfortable and reduce the amount of self-transfer attempts. R3's care plan intervention of staff to continue to anticipate needs by offering toileting and repositioning every 2 hours and walks to help mitigate irritability and self-transfers not added until 9/30/25. During an interview on 10/1/25 at 11:29 a.m., licensed practical nurse (LPN)-B stated R3 had an alarm on his wheelchair and his bed to alert staff when he attempts to self-transfer, however, R3 still is found on the floor. LPN-B was unable to articulate any further fall prevention interventions being done for R3. During an interview on 10/1/25 at 11:44 a.m., LPN- A stated because R3 falls often, staff keep a close eye on him, however, was unable to articulate how often R3 was checked on. LPN-A stated R3 had an alarm on his wheelchair and bed and was unable to articulate any further fall prevention interventions in place for R3. During an interview on 10/1/25 at 11:50 a.m., director of nursing (DON) stated R3's care plan had not been revised timely to reflect interventions that were discussed at IDT meetings following the falls on 9/3/25. 9/6/25, and 9/7/25 and the care plan should have been revised as soon a discussed, so staff are aware of the needed interventions. Review of the facility's Care Plan's Comprehensive Policy undated, identified an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Implementation as followed: -The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	Gil-Mor Manor has and always will ensure to	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0689 SS = D	Continued from page 4 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of falls for 1 of 3 residents (R3) reviewed for falls. Findings include: R3's face sheet dated 10/1/25, identified diagnoses of Alzheimer's Disease (a progressive brain leading to memory loss), diabetes mellitus (a condition where the body does not produce enough insulin), and Parkinson's disease (a progressive neurological disorder leading to movement issues). R3's Admission Minimum Data Set (MDS) dated 4/24/25, identified R3 needed moderate assistance for transfers, had two or more falls since admission, and had severe cognitive impairment. R3's fall risk focus care plan dated 4/30/25, identified R3 was high risk for falls related to history of fall and psychoactive drug use. Goal to not sustain serious injury. Interventions were as followed: -call light within reach and encourage to use if for assistance. -ensure wearing appropriate footwear with non-skid soles and gripper socks on at night. -anticipate and meet my needs. -urinal to be kept at bedside during the night. -dycem (anti-slip mat) applied to wheelchair and	F0689	Continued from page 4 comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of falls. R3 Care Plan was reviewed by IDT on 10/1/2025 to verify current fall interventions effectiveness and appropriateness. See Attachment A To ensure that this problem does not recur the Director of Nursing (DON) developed and implemented a Post Fall Review Policy and Procedure on 10/1/2025. This policy includes a monitoring system to ensure individual care plans are revised as necessary. See Attachment B Director of Nursing provided training and education to licensed staff on Fall Documentation and Immediate Intervention Process and proper assessments to be completed with every fall during Annual Skills Fair held on 11/5/2025. See Attachment C To ensure this, audits will be conducted by the Director of Nursing/designee on any falls for timeliness of documentation/assessments/Care Plan updates weekly x4 weeks, then monthly x3 months then randomly to ensure compliance. Audit results will be reported to the QAPI committee to determine ongoing compliance. See Attachment D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0689 SS = D	Continued from page 5 recliner to help prevent slipping out of my chair. -chair/bed/recliner electronic alarm. Ensure device is in place as needed. -anti-roll backs on wheelchair. -physical therapy to evaluate and treat as needed. -review information on past falls and attempt to determine cause of falls. Record root causes and alter/remove any potential causes if possible. Educate resident/family/caregivers/Interdisciplinary team (IDT) as to causes. R3's bowel incontinence focus care plan dated 4/30/25, identified R3 had bowel incontinence related to Alzheimer's disease. Intervention to check resident every 2 hours and assist with toileting as needed. R3's falls risk dated 9/7/25, identified R3 was high-risk for falls due to multiple falls within the last six months; frequently incontinent of bladder; loss of balance with standing; requires hands on assistance to move from place to place. R3's fall incident report dated 9/3/25 at 1:15 a.m., identified R3 was found on the floor in the dining room where he had been sitting in his wheelchair. R3's tab alarm was attached, however, did not go off due to the string was too long. Immediate intervention was R3 placed by the nursing station for monitoring (There was no indication the care plan was revised to include an ongoing intervention to mitigate the risk of falls.) The IDT review done on 9/4/25 identified R3 was impulsive and had confusion, does not make needs known and attempts to self-transfer frequently. Intervention that if R3 would be willing to sit at the nursing station with a tray table for his late-night snack and tab alarms shortened. There was no indication of a comprehensive investigation and analysis to identify causal factors that related to impulsivity and self-transfers was completed and no indication R2's care plan was revised until 9/30/25 with the intervention of the tray table, late night snack, and tab alarms. R3's fall incident report dated 9/6/25 at 4:00 a.m., identified R3 was found on the fall mat in his room. The incident report identified he the causal factors ambulating without assistance but did not include an immediate intervention developed and implemented to mitigate the risk of falls. IDT review was not completed until 9/8/25, which identified that	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0689 SS = D	Continued from page 6 R3 was compulsive and does not utilize the call light and does not state his needs. 1:1 would be ideal, but not feasible in this setting. Family willing to come and sit with resident when restless and irritable. Continue to toilet and reposition every 2 hours. There was no indication of a comprehensive investigation/analysis that addressed mood/behaviors and impulsivity, and the care plan was not revised with interventions that addressed the documented causes of compulsiveness and not using the call light. In addition, even though the report identified 1:1 would be ideal there was no alternatives identified other than the family would assist with supervision, but dates/times were not identified, and the care plan was not revised with the family assistance intervention until 9/29/25. R3's record identified a second fall had occurred on 9/6/25 at 4:00 p.m., This report identified R3's was found on his knees in front of recliner, after tab alarm sounded. Immediate intervention of R3 taken to the day room and had a "good rest of the night.". R3 record did not include an immediate ongoing intervention developed and implemented to mitigate the risk of falls. IDT review was not completed until 9/8/25 identified R3 was impulsive and does not utilize the call light and does not make needs known and family to sit with him when restless and agitated. R3 had a medication review done on 9/9/25 and no concerns noted. There was no indication of a comprehensive analysis to identify causal factors of the impulsivity was completed and no indication R2's care plan was revised until 9/29/25 with the intervention of family to assist with supervision. R3's fall incident report dated 9/7/25 at 7:10 a.m., identified R3's was found on knees in front of his bed. R3 was incontinent at the time for the fall. Other information added that R3 attempts to get up unassisted and that the bed alarm had been sounding. IDT review done on 9/8/25, identified R3 continues to be impulsive and not utilize the call light to ask for assistance and he strives to be independent when R3 needs assistance. Staff will anticipate R3's needs, offer toileting and repositioning and walks to keep comfortable and reduce the amount of self-transfer attempts. R3's care plan intervention of staff to continue to anticipate needs by offering toileting and repositioning every 2 hours and walks to help mitigate irritability and self-transfers not added until 9/30/25. Additionally although the incident report identified R3 was incontinent at the time of the fall there was no indication R3's toileting program was assessed for appropriateness or fall interventions were	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0689 SS = D	Continued from page 7 effective. R3 ‘s fall incident report dated 9/8/25 at 8:20 p.m., identified R3 was found sitting on the floor in front of his recliner and was incontinent of bowel. R3 self-transferred. IDT review done on 9/8/25, identified R3 continued to have lower extremity edema that required his legs to be elevated. R3 is restless in bed and recliner. 1:1 would be beneficial or sitting in the recliner at the nursing station if he R3 is willing. R3 is impulsive and does not make needs known and staff to continue to anticipate his needs and provide toileting and repositioning assistance. Alarms in place to alert staff that resident is attempting to start a self-transfer. Although potential causal factors of impulsivity and incontinence were identified there was no indication of further assessment of the effectiveness of the fall interventions nor evident new interventions were implemented and developed that addressed the causal factors identified. R3’s fall incident report dated 9/30/25 at 7:35 p.m., identified R3 was found on the floor in the dining room. R3 had removed his tab alarm from his jacket. IDT review done on 10/1/25 that IDT reviewed, and root cause identified as resident suffers from confusion and impulsivity and removed his tab alarm and intervention to change the placement to the bottom of his shirt when he is in his wheelchair. During an interview on 10/1/25 at 11:44 a.m., LPN-A stated R3 had an alarm on his wheelchair and his bed, however, R3 continues to have repeat falls. LPN-A stated staff try to keep a close eye on R3 when he is up in his wheelchair, but he is so fast and still falls. LPN-A was unable to articulate any further of R3’s fall prevention interventions. During an interview on 10/1/25 at 10:25 a.m., director of nursing (DON) stated R3’s falls had not had a comprehensive analysis, causal analysis or root cause determined for each fall and she was not aware that this needed to be done. DON stated IDT does meet to discuss each fall, however, the IDT only reviews the data for each fall and does perform a comprehensive analysis of the falls to determine the root cause of the fall nor create appropriate interventions to mitigate the risk of future falls. DON further stated R3 needed to be 1:1 at times, however, the facility is unable to provide that service, but had not create interventions for R3 to increase supervision. Review of the facility’s Falls-Clinical Protocol dated 2/18/24, identified the following:	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0689 SS = D	Continued from page 8 Cause Identification: -For an individual that has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. -If the cause of the falls in unclear, or if a fall may have a significant medical cause, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. -the staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. Monitoring and Follow-Up: -The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequence of falling. -If the interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed. -If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling and also reconsider the current interventions.	F0689		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Gil-Mor Manor has and always will ensure Enhanced Barrier Precautions (EBP) are implemented and followed during a transfer to reduce the risk of infection to others. All residents who required Enhanced Barrier Precautions have correct signage and PPE containers outside resident doors. Facility Enhanced Barrier Precautions policy was reviewed by ICP and Director of Nursing, no changes made. See Attachment E To ensure this problem does not recur the Director of Nursing and Infection Control Nurse have provided training and education to nursing department on appropriate PPE wear during Annual Skills Fair held on	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0880 SS = D	Continued from page 9 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 9 11/5/2025. See Attachment C ICP completed the CDC Nursing Home Infection Preventionist Training course on 09/12/2021. See Attachment F To ensure this, audits will be conducted by the ICP, Director of Nursing/designee on proper enhanced barrier precautions weekly x4 weeks, then monthly x3 months then randomly to ensure compliance. Audit results will be reported to the QAPI committee to determine ongoing compliance. See Attachment G	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0880 SS = D	Continued from page 10 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure Enhanced Barrier Precautions (EBP)- (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities), were implemented or followed during a transfer to reduce the risk of infection to others for 1 of 1 resident (R3). Findings include: R3's admission Minimum Data Set (MDS) dated 4/24/25, identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and diabetes. R3's order summary dated 8/30/25, identified an order to clean wound on top of left foot, apply clean Mepilex (absorbent foam dressing) due to drainage and extremity weeping in the AM and check and make sure the dressing is dry and intact due to weeping and drainage in the PM. R3's care plan was reviewed and did not identify the need for EBP with high-risk cares due to a weeping wound on top of his left foot. R3's Treatment Administration Record (TAR) dated November 2025 identified R3's left foot wound to clean wound and apply clean Mepilex due to drainage and extremity weeping in the AM and check and make sure the dressing is dry and intact due to weeping and drainage in the PM. During an observation and interview on 10/1/25 at 9:09 a.m., upon entrance to the left of R3's door was a paper sign taped to the wall. There were two "STOP" signs noted. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheotomy. Wound care: any skin opening	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0880 SS = D	Continued from page 11 requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had pictures of hand cleanser, gloves, and gown. There was a personal protective equipment (PPE) cart across the hallway observed. Nursing assistant (NA)-B and director of nursing DON walked in R1's room without applying PPE and DON proceeded to apply a gait belt around R3 while her body was touching R3's body. NA-B applied gloves and had R3 stand up, NA-B pulled R3's pants down and put a new brief on R3 and proceeded to change R3's pants as they were wet. NA-B stated she did not use EBP because she thought you only needed to use EBP for emptying a catheter or doing wound change. NA-B further stated R3 was not on EBP because he did not have a PPE cart outside his room but did verify the EBP sign was outside his door. During an interview on 10/1/25 at 9:23 a.m., licensed practical nurse (LPN)-A stated staff should be using EBP with transfers and toileting due to the wound on R3's left foot. During an interview on 10/1/25 at 9:24 a.m., infection preventionist Registered nurse (IP/RN) stated R3 has a wound on his left foot and staff should be using EBP to include gown and gloves with high contact cares like toileting and transfers. IP/RN stated gowns and gloves she be worn by all staff when an EBP sign was on a resident's door. During an interview on 10/1/25 at 10:17 a.m., DON stated she was under the assumption that EBP only needed to be used with wound or catheter cares not with transfers and toileting. Facility policy, "Enhanced Barrier Precautions," effective 11/4/24, identified a purpose: This policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within Gil-Mor Manor by implementing Enhanced Barrier Precautions (EBP). This policy seeks to prevent the spread of MDROs among residents and staff members by expanding the use of personal protective equipment (PPE) during high-contact care activities for certain residents. Policy Statement: To implement Enhanced Barrier Precautions to reduce the transmission of multidrug-resistant organisms in Gil-Mor Manor. EBP-are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP expands upon Standard Precautions by requiring the use of gowns and gloves during specific high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (e.g., residents	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245594	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 THIRD STREET EAST , MORGAN, Minnesota, 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
F0880 SS = D	Continued from page 12 with wounds or indwelling medical devices). Residents on EBP are not restricted to their rooms and are not restricted from participating in group activities or therapy outside of their room. High-contact resident care activities- are activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Examples of high-contact resident care activities requiring gown and glove use for residents on EBP include, but are not limited to: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting (including ostomy care), indwelling medical device care and wound care: chronic wounds… EBP should be used for any residents who meet the above criteria, wherever they reside in the facility.	F0880		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/26/25 and 9/30/25, and 10/1/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		12/26/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20000	Continued from page 1 The following complaints were reviewed. H55945072C (2624396) with a licensing order issued at:830, 570, and 1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	20570	CORRECTED	01/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20570	Continued from page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan with fall interventions following falls for 1 of 3 residents (R3) reviewed for falls. Findings include R3's face sheet dated 10/1/25, identified diagnoses of Alzheimer's Disease (a progressive brain leading to memory loss), diabetes mellitus (a condition where the body does not produce enough insulin), and Parkinson's disease (a progressive neurological disorder leading to movement issues). R3's Admission Minimum Data Set (MDS) dated 4/24/25, identified R3 needed moderate assistance for transfers, had two or more falls since admission, and had severe cognitive impairment. R3's fall risk focus care plan dated 4/30/25, identified R3 was high risk for falls related to history of fall and psychoactive drug use. Goal to not sustain serious injury. Interventions were as followed: -call light within reach and encourage to use if for assistance. -ensure wearing appropriate footwear with non-skid soles and gripper socks on at night. -anticipate and meet my needs. -urinal to be kept at bedside during the night. -dycem (anti-slip mat) applied to wheelchair and recliner to help prevent slipping out of my chair. -chair/bed/recliner electronic alarm. Ensure device is in place as needed. -anti-roll backs on wheelchair. -physical therapy to evaluate and treat as needed. -review information on past falls and attempt to determine cause of falls. Record root causes and alter/remove any potential causes if possible. Educate	20570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20570	Continued from page 3 resident/family/caregivers/Interdisciplinary team (IDT) as to causes. R3's fall incident report dated 9/3/25 at 1:15 a.m., identified R3 was found lying on the floor in the dining room where he was sitting in his wheelchair with alarm was attached, however, the alarm did not go off as the string was too long. Immediate action taken was R3 to be placed by the nursing station for monitoring. IDT review done on 9/4/25 identified R3 was impulsive and had confusion, does not make needs known and attempts to self-transfer frequently and if R3 was willing to sit by the nursing station with a tray table for his late-night snack and tab alarms shortened. R3's care plan did not identify an intervention that R3 can sit at nurse's station for a snack utilizing a tray table to staff can keep a closer eye on him until 9/30/25. R3's fall incident report dated 9/6/25 at 4:00 a.m., identified R3's was found on his knees next to his bed on the fall mat and had sustained an abrasion to his right knee. IDT review done on 9/8/25, identified that R3 was compulsive and does not utilize the call light and does not state his needs. 1:1 would be ideal, but not feasible in this setting. Family willing to come and sit with resident when restless and irritable. Continue to toilet and reposition every 2 hours. R3's fall incident report dated 9/6/25 at 4:00 p.m., identified R3's alarm sounded, and he was found on his knees in front of his recliner after his tab alarm sounded. R3 stated he was attempting to get out of his chair and without this thing going off and now you caught me. R3 was taken to the day room and had a good rest of the night. IDT review done on 9/8/25 identified R3 was impulsive and does not utilize the call light and does not make needs known and family to sit with him when restless and agitated. R3 had a medication review done on 9/9/25 and no concerns noted. R3's care plan intervention of family to provide 1:1 when available or needed and to continue to be toileted every 2 hours not revised until 9/29/25 . R3's fall incident report dated 9/7/25 at 7:10 a.m., identified R3's was found on knees in front of his bed. R3 was incontinent at the time for the fall. Other information that R3 attempts to get up unassisted and that the bed alarm was sounding. IDT review done on 9/8/25, identified R3 continues to be impulsive and not utilize the call light to ask for assistance and he strives to be independent when R3 needs assistance. Staff will anticipate R3's needs, offer toileting and	20570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20570	Continued from page 4 repositioning and walks to keep comfortable and reduce the amount of self-transfer attempts. R3's care plan intervention of staff to continue to anticipate needs by offering toileting and repositioning every 2 hours and walks to help mitigate irritability and self-transfers not added until 9/30/25. During an interview on 10/1/25 at 11:29 a.m., licensed practical nurse (LPN)-B stated R3 had an alarm on his wheelchair and his bed to alert staff when he attempts to self-transfer, however, R3 still is found on the floor. LPN-B was unable to articulate any further fall prevention interventions being done for R3. During an interview on 10/1/25 at 11:44 a.m., LPN- A stated because R3 falls often, staff keep a close eye on him, however, was unable to articulate how often R3 was checked on. LPN-A stated R3 had an alarm on his wheelchair and bed and was unable to articulate any further fall prevention interventions in place for R3. During an interview on 10/1/25 at 11:50 a.m., director of nursing (DON) stated R3's care plan had not been revised timely to reflect interventions that were discussed at IDT meetings following the falls on 9/3/25. 9/6/25, and 9/7/25 and the care plan should have been revised as soon a discussed, so staff are aware of the needed interventions. Review of the facility's Care Plan's Comprehensive Policy undated, identified an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Implementation as followed: -The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary.	20570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20570	Continued from page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, implement appropriate interventions and implement/revise the care plan to prevent and/or reduce the risk of falls for 1 of 3 residents (R3) reviewed for falls. Findings include R3's face sheet dated 10/1/25, identified diagnoses of Alzheimer's Disease (a progressive brain leading to memory loss), diabetes mellitus (a condition where the body does not produce enough insulin), and Parkinson's disease (a progressive neurological disorder leading to movement issues). R3's Admission Minimum Data Set (MDS) dated 4/24/25, identified R3 needed moderate assistance for transfers, had two or more falls since admission, and had severe cognitive impairment. R3's fall risk focus care plan dated 4/30/25, identified R3 was high risk for falls related to history of fall and psychoactive drug use. Goal to not sustain serious injury. Interventions were as followed: -call light within reach and encourage to use if for assistance. -ensure wearing appropriate footwear with non-skid soles and gripper socks on at night. -anticipate and meet my needs.	20830	CORRECTED	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20830	Continued from page 6 -urinal to be kept at bedside during the night. -dycem (anti-slip mat) applied to wheelchair and recliner to help prevent slipping out of my chair. -chair/bed/recliner electronic alarm. Ensure device is in place as needed. -anti-roll backs on wheelchair. -physical therapy to evaluate and treat as needed. -review information on past falls and attempt to determine cause of falls. Record root causes and alter/remove any potential causes if possible. Educate resident/family/caregivers/Interdisciplinary team (IDT) as to causes. R3's bowel incontinence focus care plan dated 4/30/25, identified R3 had bowel incontinence related to Alzheimer's disease. Intervention to check resident every 2 hours and assist with toileting as needed. R3's falls risk dated 9/7/25, identified R3 was high-risk for falls due to multiple falls within the last six months; frequently incontinent of bladder; loss of balance with standing; requires hands on assistance to move from place to place. R3's fall incident report dated 9/3/25 at 1:15 a.m., identified R3 was found on the floor in the dining room where he had been sitting in his wheelchair. R3's tab alarm was attached, however, did not go off due to the string was too long. Immediate intervention was R3 placed by the nursing station for monitoring (There was no indication the care plan was revised to include an ongoing intervention to mitigate the risk of falls.) The IDT review done on 9/4/25 identified R3 was impulsive and had confusion, does not make needs known and attempts to self-transfer frequently. Intervention that if R3 would be willing to sit at the nursing station with a tray table for his late-night snack and tab alarms shortened. There was no indication of a comprehensive investigation and analysis to identify causal factors that related to impulsivity and self-transfers was completed and no indication R2's care plan was revised until 9/30/25 with the intervention of the tray table, late night snack, and tab alarms. R3's fall incident report dated 9/6/25 at 4:00 a.m., identified R3 was found on the fall mat in his room. The incident report identified he the causal factors ambulating without assistance but did not	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20830	Continued from page 7 include an immediate intervention developed and implemented to mitigate the risk of falls. IDT review was not completed until 9/8/25, which identified that R3 was compulsive and does not utilize the call light and does not state his needs. 1:1 would be ideal, but not feasible in this setting. Family willing to come and sit with resident when restless and irritable. Continue to toilet and reposition every 2 hours. There was no indication of a comprehensive investigation/analysis that addressed mood/behaviors and impulsivity, and the care plan was not revised with interventions that addressed the documented causes of compulsiveness and not using the call light. In addition, even though the report identified 1:1 would be ideal there was no alternatives identified other than the family would assist with supervision, but dates/times were not identified, and the care plan was not revised with the family assistance intervention until 9/29/25. R3's record identified a second fall had occurred on 9/6/25 at 4:00 p.m., This report identified R3's was found on his knees in front of recliner, after tab alarm sounded. Immediate intervention of R3 taken to the day room and had a "good rest of the night.". R3 record did not include an immediate ongoing intervention developed and implemented to mitigate the risk of falls. IDT review was not completed until 9/8/25 identified R3 was impulsive and does not utilize the call light and does not make needs known and family to sit with him when restless and agitated. R3 had a medication review done on 9/9/25 and no concerns noted. There was no indication of a comprehensive analysis to identify causal factors of the impulsivity was completed and no indication R2's care plan was revised until 9/29/25 with the intervention of family to assist with supervision. R3's fall incident report dated 9/7/25 at 7:10 a.m., identified R3's was found on knees in front of his bed. R3 was incontinent at the time for the fall. Other information added that R3 attempts to get up unassisted and that the bed alarm had been sounding. IDT review done on 9/8/25, identified R3 continues to be impulsive and not utilize the call light to ask for assistance and he strives to be independent when R3 needs assistance. Staff will anticipate R3's needs, offer toileting and repositioning and walks to keep comfortable and reduce the amount of self-transfer attempts. R3's care plan intervention of staff to continue to anticipate needs by offering toileting and repositioning every 2 hours and walks to help mitigate irritability and self-transfers not added until 9/30/25. Additionally although the incident report	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20830	Continued from page 8 identified R3 was incontinent at the time of the fall there was no indication R3's toileting program was assessed for appropriateness or fall interventions were effective. R3 's fall incident report dated 9/8/25 at 8:20 p.m., identified R3 was found sitting on the floor in front of his recliner and was incontinent of bowel. R3 self-transferred. IDT review done on 9/8/25, identified R3 continued to have lower extremity edema that required his legs to be elevated. R3 is restless in bed and recliner. 1:1 would be beneficial or sitting in the recliner at the nursing station if he R3 is willing. R3 is impulsive and does not make needs known and staff to continue to anticipate his needs and provide toileting and repositioning assistance. Alarms in place to alert staff that resident is attempting to start a self-transfer. Although potential causal factors of impulsivity and incontinence were identified there was no indication of further assessment of the effectiveness of the fall interventions nor evident new interventions were implemented and developed that addressed the causal factors identified. R3's fall incident report dated 9/30/25 at 7:35 p.m., identified R3 was found on the floor in the dining room. R3 had removed his tab alarm from his jacket. IDT review done on 10/1/25 that IDT reviewed, and root cause identified as resident suffers from confusion and impulsivity and removed his tab alarm and intervention to change the placement to the bottom of his shirt when he is in his wheelchair. During an interview on 10/1/25 at 11:44 a.m., LPN-A stated R3 had an alarm on his wheelchair and his bed, however, R3 continues to have repeat falls. LPN-A stated staff try to keep a close eye on R3 when he is up in his wheelchair, but he is so fast and still falls. LPN-A was unable to articulate any further of R3's fall prevention interventions. During an interview on 10/1/25 at 10:25 a.m., director of nursing (DON) stated R3's falls had not had a comprehensive analysis, causal analysis or root cause determined for each fall and she was not aware that this needed to be done. DON stated IDT does meet to discuss each fall, however, the IDT only reviews the data for each fall and does perform a comprehensive analysis of the falls to determine the root cause of the fall nor create appropriate interventions to mitigate the risk of future falls. DON further stated R3 needed to be 1:1 at times, however, the facility is unable to provide that service, but had not create interventions for R3 to increase supervision.	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
20830	Continued from page 9 Review of the facility's Falls-Clinical Protocol dated 2/18/24, identified the following: Cause Identification: -For an individual that has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. -If the cause of the falls in unclear, or if a fall may have a significant medical cause, or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. -the staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. Monitoring and Follow-Up: -The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequence of falling. -If the interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed. -If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling and also reconsider the current interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. F689	20830		
21390	Infection Control	21390	CORRECTED	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
21390	Continued from page 10 CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure Enhanced Barrier Precautions (EBP)- (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities), were implemented or followed during a transfer to reduce the risk of infection to others for 1 of 1 resident (R3). Findings include R3's admission Minimum Data Set (MDS) dated 4/24/25, identified R1 had severe cognitive impairment and had	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
21390	Continued from page 11 diagnoses of Alzheimer's disease and diabetes. R3's order summary dated 8/30/25, identified an order to clean wound on top of left foot, apply clean Mepilex (absorbent foam dressing) due to drainage and extremity weeping in the AM and check and make sure the dressing is dry and intact due to weeping and drainage in the PM. R3's care plan was reviewed and did not identify the need for EBP with high-risk cares due to a weeping wound on top of his left foot. R3's Treatment Administration Record (TAR) dated November 2025 identified R3's left foot wound to clean wound and apply clean Mepilex due to drainage and extremity weeping in the AM and check and make sure the dressing is dry and intact due to weeping and drainage in the PM. During an observation and interview on 10/1/25 at 9:09 a.m., upon entrance to the left of R3's door was a paper sign taped to the wall. There were two "STOP" signs noted. Signage read: "ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheotomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person." The sign also had pictures of hand cleanser, gloves, and gown. There was a personal protective equipment (PPE) cart across the hallway observed. Nursing assistant (NA)-B and director of nursing DON walked in R1's room without applying PPE and DON proceeded to apply a gait belt around R3 while her body was touching R3's body. NA-B applied gloves and had R3 stand up, NA-B pulled R3's pants down and put a new brief on R3 and proceeded to change R3's pants as they were wet. NA-B stated she did not use EBP because she thought you only needed to use EBP for emptying a catheter or doing wound change. NA-B further stated R3 was not on EBP because he did not have a PPE cart outside his room but did verify the EBP sign was outside his door. During an interview on 10/1/25 at 9:23 a.m., licensed practical nurse (LPN)-A stated staff should be using EBP with transfers and toileting due to the wound on R3's left foot.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
21390	Continued from page 12 During an interview on 10/1/25 at 9:24 a.m., infection preventionist Registered nurse (IP/RN) stated R3 has a wound on his left foot and staff should be using EBP to include gown and gloves with high contact cares like toileting and transfers. IP/RN stated gowns and gloves she be worn by all staff when an EBP sign was on a resident's door. During an interview on 10/1/25 at 10:17 a.m., DON stated she was under the assumption that EBP only needed to be used with wound or catheter cares not with transfers and toileting. Facility policy, "Enhanced Barrier Precautions," effective 11/4/24, identified a purpose: This policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within Gil-Mor Manor by implementing Enhanced Barrier Precautions (EBP). This policy seeks to prevent the spread of MDROs among residents and staff members by expanding the use of personal protective equipment (PPE) during high-contact care activities for certain residents. Policy Statement: To implement Enhanced Barrier Precautions to reduce the transmission of multidrug-resistant organisms in Gil-Mor Manor. EBP- are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP expands upon Standard Precautions by requiring the use of gowns and gloves during specific high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Residents on EBP are not restricted to their rooms and are not restricted from participating in group activities or therapy outside of their room. High-contact resident care activities- are activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Examples of high-contact resident care activities requiring gown and glove use for residents on EBP include, but are not limited to: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting (including ostomy care), indwelling medical device care and wound care: chronic wounds… EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation and or/enhanced	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	**96 THIRD STREET EAST , MORGAN, Minnesota, 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
21390	Continued from page 13 barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		