STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Morningside Heights Care Center	300 South Bruce Street Marshall, MN 56258

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on interview and document review, the facility failed to ensure staff appropriately assessed, monitored, intervened, and notified the family in a timely manner after a fall for 1 of 1 resident (R1) resulting in a brain bleed and skull fracture causing serious harm and eventual death. The immediate jeopardy (IJ) began 9/15/25 at 10:23 p.m., when the facility failed to ensure staff appropriately assessed, monitored, and intervened after a fall for 1 of 1 resident (R1) who had an unwitnessed fall with visible facial bruising and facial structure abnormalities, that resulted in delayed medical examination by a physician and early treatment. R1 was finally transferred to the emergency room 9 hours post fall to the local hospital, where a brain bleed and skull fracture were discovered resulting in serious harm and eventual death. The facility administrator and director of nursing were notified of the IJ on 9/24/25 at 12:34 p.m. The facility had implemented immediate corrective action beginning 9/18/25 through 9/21/25, to prevent recurrence; therefore, the IJ was issued at PAST NON-COMPLIANCE. Findings include: The initial report to the State Agency (SA) identified on:1. 9/15/25 at 11:23 p.m., trained medication aide/nurse aide (NA)-A went to check on R1 and when she opened door to his room, he was found sitting on the floor in front of his recliner. The lights were on, and his walker was over by the closet. His face was bruised, purple, and he had swelling around his eyes. His nose was bruised and yellow. His fingers were covered with a small amount of red blood, and his thumb fingernail was broken at the tip. He had purple bruising and dry blood on the back of his hand. R1's brief was dry, and he denied having pain and hitting his head. He was alert and oriented to person and time. His neuros were reported as stable after the fall. Registered nurse (RN)-A removed his arm rest protectors from his recliner and educated R1 on using his breaks on his four-wheeled walker. There was no indication in the report staff had contacted a physician or family member for R1 immediately after the fall or sent R1 to the emergency room at the adjacent hospital for medical evaluation.2. 9/16/25 at 1:15 a.m., R1 began to report a headache and was given as needed (PRN) Tylenol 650 mg via standing orders. RN-A called the E-Care physician (on-call telemedicine physician) to report R1 now had a headache, was vomiting, had increased blood pressure (BP), and was noted to be shaking. The E-Care physician visited with R1 via telehealth (video over computer screen). R1 was vomiting into a trash can and complaining his head hurt. The E-Care provider recommended R1 take Zofran (anti-nausea medication) and wait for the Tylenol to kick in. R1 was noted to have vomited shortly after taking the Tylenol. There was no indication in the report, that the E-Care provider nor RN-A had identified an emergent situation that indicated potential head injury.3. 9/16/25 at 3:00 a.m., R1's oxygen level was identified to begin to drop between 86%-89% [oxygen saturation (SpO2)] (92% to 100% is normal range), which was reported to be not his baseline. RN-A then administered an Albuterol nebulizer (inhaled medication) treatment via standing orders at 3:34 a.m R1's oxygen increased to 90% SpO2 for 30 minutes but then reverted back to 86%-88% SpO2. RN-A called E-care back at that time to report change a in condition. R1 reported his headache pain was less painful, and he was no longer vomiting. The E-care provider then ordered a chest x ray STAT (immediately), a urinalysis specimen (UA) with culture, and some blood specimens and additional medication orders. There was no evidence that RN-A disclosed the previous E-Care physician's call, order changes, R1's recent fall, or identified the seriousness of the incident and the need to send R1 to the emergency room for in-person evaluation by a physician.4. 9/16/25 at 5:00 a.m., a nurse aide reported to RN-A that R1 had begun vomiting again. RN-A then called E-Care again requesting a computerized tomography (CT) scan of his head. The E-Care physician told RN-A since R1 was alert and could read questions (R1 had limited hearing so he was asked to read questions rather than hear them asked) used to assess his cognition, they did not believe R1 needed CT scan of his head and only gave order for an X-ray of his. RN-A then entered the orders from the E-Care physician. There was no mention in the report either the E-Care provider, nor RN-A had yet identified the seriousness of R1's condition.5. 9/16/25 at approximately 7:30 a.m., when R1's primary care physician (NP-C) arrived, he was notified of R1's fall and asked to evaluate R1. PCP directed staff to send R1 to the ER where a head CT was completed and it was noted there were bilateral skull fractures, bilateral brain bleeds, bilateral hemorrhagic contusions (bleeding and bruising) and a subarachnoid hemorrhage(bleeding in the space below one of the thin layers that cover and protect your brain) in the frontal and temporal (side) lobes and a right parietal intraventricular hemorrhage (bleeding in the cerebral ventricular system). Staff noted the call light was not sounding at the time of the fall. The facility identified R1's care plan had been followed. R1's 7/23/25, quarterly Minimum Data Set (MDS) assessment identified R1 was admitted in December 2022 with