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	03/24/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure adequate supervision was provided to prevent falls for 1 of 3 residents (R2) reviewed for falls. R2 needed increased monitoring for safety due to her fall risk with one-to-one (1:1) supervision which was not provided when the nursing assistant (NA) left R2 alone to go wash their hands. R2 then fell causing harm when R2 obtained a left olecranon (elbow) fracture which needed surgery. Findings include: R2's progress note, dated 1/2/26, identified R2 admitted to the nursing home from the hospital. R2 was an assistance of two staff with an EZ Stand for transfers and was non-weight bearing (NWB) to her right upper extremity with a sling on at all times. R2 was recorded as not verbally responding and having poor memory due to dementia. R2's Fall Risk Assessment, dated 1/2/26, identified R2 had sustained a fall within the last three months, had altered mental status, impaired mobility, and consumed at-risk medications. The assessment scored R2 as, 5: Higher fall risk precautions, and directed interventions which included non-skid footwear and PT/OT. R2's 5-Day Minimum Data Set (MDS), dated [DATE], identified R2 had severe cognitive impairment and had sustained falls prior to admission with a fracture. R2's corresponding Falls Care Area Assessment (CAA), dated 1/10/26, identified R2 had advanced dementia with severe aphasia (communication disorder) and was rarely understood. The CAA recorded R2 had sustained a fall prior to her admission with fracture obtained (right elbow) and listed her being not behavioral but just busy which placed her at continued high risk for falls. The CAA identified R2's assessed risks as falls, pain, injury, and decline. R2's progress note, dated 1/11/26, identified R2 had a fall on 1/10/26 at 9:12 a.m. with dictation, . [R2] had been one on one with staff in the evening due to restlessness for her safety. Staff were with [R2] in the open area dining room giving her a snack and getting her settled after her HS [bedtime] medications had been given. Staff were needed to help a two-assist resident, so were called away. It is estimated that about two minutes lapsed from the time they had to leave her to the time this writer came around the corner in the dining room area where she was found in the middle of the room on the floor with her wheelchair behind her. The fall resulted in two lacerations above her left eye, a small bleed on her left elbow, a skin tear, and a hematoma. The provider was updated and ordered R2 to be seen in the emergency department (ED). Registered nurse (RN)-D authored the note. R2's FSI - Fall Scene Investigation Report, dated 1/10/26, identified a section to record the fall details. This identified a hand-drawn photo of how R2 was found on the floor with injuries listed as head laceration and left elbow skin tear. Just prior to the fall, R2 was recorded as sitting by kitchen self-propelling in the wheelchair facing the staff. The staff was called away for a two person assist, then staff came back and gave her a snack, then left again to help another resident when R2 was then found on the floor. R2 hit her head due to the unwitnessed fall. The report included a section to be completed by the primary NA working with R2 who recorded, The patient has been one on one with the writer, offered snacks and drinks and has been moving with the wheelchair all around the unit all under watch. The NA then pushed R2 next to a patient room where the other NA needed help. The NA then left R2 to assist the other NA, returned and spoke with R2, and then left again to dispose of the trash. NA-C authored this section of (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
	245228	A. Building B. Wing	03/24/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	the note. The report continued and listed a section labeled, Root Cause of This Fall, which identified a checkmark placed next to R2's medical status and mental status with handwritten, Severe Dementia. The section asked, What appears to be the root cause of the fall[?], which was answered in writing by RN-D as, She was not one on one - self-propelled [sic] herself and attempted to get up and fell. A new intervention was written that if staff have to leave R2 unattended, they should let the nurse know so options can be assessed. R2's Fall Follow Up, dated 1/10/26, identified an initial evaluation of the fall and repeated several items from RN-D's progress note along with R2 being sent to the hospital ED and diagnosed with a displaced olecranon fracture. The report identified registered nurse manager (RN)-B was notified of the fall. A section labeled, Fall Severity, identified R2 as having sustained, Major Injury. A section labeled, Post Fall Investigation, identified R2 had sustained falls in the last week or more than three times within the past 30-day period with notes, [R2] admitted to our facility post status right hip fx [fracture] and right arm fx. The intervention placed for this fall on 1/10/26 was if staff were called away to assist others and R2 could not be placed next to a table to prevent her leaning forward, to let a nurse know so options can be explored. A subsequent Follow Up, dated 1/11/26, identified the fall from 1/10/26 but this time included a section labeled, Post Fall Education Additional Information, which directed an intervention was communicated with staff that if they need to leave R2 unattended when she is not settled that they need to tell the nurse so something can be done to get someone by her. A corresponding Threshold Investigation Worksheet, undated, identified R2's fall on 1/10/26 was reviewed by the nursing team. R2's progress note (dated 1/11/26 by RN-D) was reposted to it as background information with a section below which posed arrows going down for staff to ask, WHY? after each item identified. This recorded only two items which were, Why did [R2] fall? > She was trying to get up to find someone. The report identified two strengths from the situation, in which staff identified R2 needed to be a 1:1 due to anxiousness and attempted to see if she had unmet needs. The one opportunity they determined was, Better communication surrounding when staff need to leave a resident due to caring for another resident. R2's Emergency Department (ED) Discharge Plan, dated 1/10/26, identified R2 was seen in an ED for a fall at the nursing home which left an abrasion of her elbow, forehead laceration, and a closed olecranon fracture. R2 presented with advanced dementia and was found on the floor in front of her chair with exact details of the fall being unknown. R2 was recorded as non-verbal at baseline but said, Ow, with movement in the ED so an x-ray was ordered which identified a left elbow olecranon fracture. R2 was placed in a sling, and an orthopedic follow-up was recommended. R2 was discharged back to the nursing home. R2's care plan, dated 1/30/26, identified R2 was at risk for falls or injury due to a history of prior falls and poor balance. The plan listed interventions recorded as Safety Measures, being last revised on 1/11/26. These included notifying the nurse if the NA has to leave her alone, offering food or toileting if restless, and using busy boards or wildlife shows to occupy her time. The care plan lacked any current or historical recorded intervention for 1:1 supervision despite the progress notes saying one was needed. R2's progress note, dated 2/12/26, identified R2 went to an orthopedic appointment with her family member present. The x-rays showed stable alignment of the left elbow and family agreed to proceed with surgery. R2 was ordered to continue with the Exos brace (splint used for fractures in hand or elbow) and orthopedics would schedule an open-reduction internal fixation (ORIF) left olecranon fracture. R2's progress note, dated 2/25/26, identified R2 was sent to same-day surgery for the procedure and returned NWB on her left elbow and with new pain medication prescriptions. During observation on 3/23/26 at 1:22 p.m., R2 was seated in a high-back wheelchair in the commons area of the unit watching television. R2 appeared comfortable and had a black-colored sling on her left arm. R2 smiled when conversed with, however, did not respond to many questions or mumbled a response which was undiscernible. R2 was asked if she had fallen at all in the past months which she did answer, No, and smiled. When interviewed on 3/23/26 at 1:24 p.m., NA-A stated they were working with R2 and described her as needing help with most cares including eating. NA-A stated R2 used the sling on her left arm since she came to the unit from the TCU several (continued on next page)

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	03/24/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	weeks prior. NA-A stated they knew R2 had fallen in the TCU but was not sure whether she had gotten injured or not with it. NA-A stated R2 had not sustained anymore falls since she moved to the new unit and R2 was not as active on this unit as she had been on the TCU. NA-A stated staff tried to keep a close eye on her and kept her in the commons area, often including at nighttime but was not on a formal 1:1 anymore. NA-A stated if a resident were on 1:1 and they had to leave them, they would wait to find a nurse or someone else to sit with them first. When interviewed on 3/24/26 at 7:24 a.m., NA-B recalled working on 1/10/26 when R2 fell. NA-C was sitting with R2 in the commons area when NA-B needed help in another room, so NA-C placed R2 while seated in the wheelchair outside the door and told R2 to be patient while they helped. They finished the care and NA-C then left the room while NA-B stayed in the room to clean up. NA-B stated NA-C had then left R2 unattended in the dining room area while leaving to wash their hands and throw trash away. RN-D came into the dining room and found R2 on the floor. NA-B stated R2 did not have any injuries or issues with her left arm or elbow prior to the fall on 1/10/26. NA-B recalled R2 as being 1:1 with staff before she fell that evening due to her cognition. NA-B stated if someone was a 1:1, then staff needed to remain with them and have constant supervision on them and if R2 was in the dining room and someone left to go to soiled utility it would have been out of sight. NA-B stated they were unsure why NA-C did not just wash their hands in the kitchen sink which was in the same room as R2. Following the fall, NA-B stated themselves, NA-C, and RN-D then decided to make sure the RN would be asked to sit with R2 if staff needed to leave her again instead of just leaving her unsupervised. NA-B stated nobody from management had told them that, it was just them working when it happened who decided that. NA-B reiterated a 1:1 means someone needs to always stay with the person and had that been done R2's fall was likely preventable. When interviewed on 3/24/26 at 8:03 a.m., NA-C stated they recalled R2 as being a fall risk and were assigned to R2 when she fell on 1/10/26. NA-C stated they were called to help with another patient by NA-B, so they moved R2 next to the door of that room and told R2 to stay there and they had come back. NA-C then went inside the other resident room and closed the door. When they opened it upon completion of care, R2 had wheeled herself back into the dining room. NA-C again told R2 to stay there and left to go dispose of trash and wash their hands down the hall while out of sight of R2. NA-C was washing their hands when suddenly RN-D called for help and R2 was on the floor. NA-C recalled R2 being very confused that night and stated they did not call for help prior to leaving R2 as they told R2 to wait there and would be right back. NA-C recalled R2 being a 1:1 as she had worked with her prior and she was a 1:1 then adding, We knew that [1:1]. The RN had told them R2 was a 1:1 that night, too, adding aloud, This patient is a 1:1. NA-C stated a 1:1 meant someone should stay with them at all times but again acknowledged leaving the patient quick to wash their hands when she fell. NA-C stated the group involved with the fall then discussed it and talked about how to prevent it again but nobody had discussed or provided re-education on a 1:1 and it's expectations since then though adding aloud, I can't recall that they talked about that. An interview was attempted with RN-D during the abbreviated survey; however, they were on leave and unavailable for interview per the campus administration. On 3/24/26 at 10:05 a.m., a group interview was held with registered nurse unit manager (RN)-B and the director of nursing (DON). RN-B explained someone's fall risk was assessed upon admission and then care plan interventions would be placed from that assessment. These interventions were kinda generalized until they learned more about the resident then more specific interventions would be identified. RN-B stated R2 was admitted with fractures from a fall in her right arm, and the new left elbow fracture happened from the fall on 1/10/26, with R2 possibly being on 1:1 that night due to being more busy and moving around more. It was not care planned but rather had just been nurse driven as an intervention. DON stated they felt there were different avenues someone could use if on 1:1 including just frequent checks versus constant supervision adding staff were trying our best to keep her in the line of sight they felt. DON stated there was not a specific policy or procedure for 1:1 to help define the exact expectations with it, which they had just talked with the administrator and identified as a takeaway from this situation. (continued on next page)

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	03/24/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	DON stated they felt the documentation listed in the progress notes and FSI meant to watch R2 closely but did not necessarily mean keeping constant eyesight of her. DON stated if R2 had been 1:1 like they'd expect for a suicide-risk (i.e., direct, constant supervision) then R2's fall was likely preventable but if it was just frequent checks like they felt this situation to be, then there was a chance a fall could still happen despite. Following the fall, some general education on teamwork had been sent to all staff members and RN-B stated they believed they discussed 1:1 expectation at a NA meeting since the fall and would provide that documentation. At 10:38 a.m., RN-B reviewed the agenda from their unit meeting (dated 1/29/26) which identified a discussion labeled, 1:1 activities / what is 1:1, and, Prevent fractures from self-transfers, with an attached sign-in sheet listing employee names and a X if attended. This listing had a total of 91 active employees (as of 1/29/26) but 51 of them did not have an X to demonstrate re-education on the topics. RN-B stated they recalled having discussion on 1:1 at the meeting and using teamwork to ensure supervision is provided when needed. RN-B acknowledged the multiple names on the listing without re-education and stated they were still trying to get some people caught up on it and working on a different system to get better attendance at the meetings. RN-B verified the nurses of the unit were not included in the re-education, either, since it was specific to NA staff members. When interviewed on 3/26/26 at 11:06 a.m., RN-C stated they were currently assigned to R2 and were aware R2 had fallen on the TCU prior and obtained an elbow fracture from it. RN-C stated if they directed a 1:1 for a patient then they expected the NA to have eyesight of them at all times. RN-C there had been no discussion of 1:1's or their expectation to the nurses on it recently to their recall adding, Not that I'm aware of. On 3/24/26 at 12:04 p.m., the DON and administrator were interviewed. DON stated they did not feel the language in the FSI, and progress notes meant a direct 1:1 needed prior to R2's fall but rather the documentation supported that was maybe a new intervention to do post-fall. DON stated the NA staff may have identified R2 was restless and needed more supervision on 1/10/26 and felt they could handle it themselves. DON reiterated they did not feel the language in the chart reflected a 1:1 was needed prior to the fall. The facility LTC (Long-term Care) Falls and Accidents policy, dated 10/2024, identified supervision defined as a determination based on the individual resident's assessed needs and identified hazards in the environment. This added, Adequate supervision may vary from resident to resident and from time to time for the same resident. The policy directed staff would be educated on preventing residents' falls and have access to the care plans for each resident. The resident would also be assessed for fall risk and based upon that, have individualized interventions in place to reduce the risk.