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	12/03/2025

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the facility failed to ensure its Quality Assurance Performance Improvement (QAPI) program provided supervision for 1 of 1 infection preventionist (IP), to identify a thorough infection control surveillance program included surveillance of all employee illness. QAPI also failed to ensure employee surveillance was appropriately delegated to personnel in employee health (EH) who were not certified in infection control. This had the potential to affect all 74 residents. Refer to F880 and F882Findings include: Review of the current, facilities infection control surveillance for employees identified the facility utilized corporate employee health to track employee illness. The IP failed to have any oversight for employee illness and relied on corporate employee health (EH) to provide facility employee surveillance. There was no documentation to support the IP was made aware by EH daily of staff call-ins, had oversight to ensure staff would remain out of work, used that daily data to correlated staff illness to potential resident illness, and ensure staff were appropriately screened for their ability to safely return to work. In addition, QAPI failed to ensure EH had an employee certified in IP since they were delegated with monitoring employee illness. Interview on 12/2/25 at 4:10 p.m., with the infection preventionist (IP) identified employee's call central employee health (EH) when ill to report their symptoms, EH then provides the employee general guidelines of when they can return to work. The manager will get a call that the staff called in ill and when they can return to work based on the employee's illness. If employee heath identified a trend in employee illness, then EH would reach out to notify her so she could compare with the facility residents to see if there was any correlation. She revealed that she did not keep a record of employee illness only EH had that documentation. She was responsible for the resident surveillance at the facility and that EH tracked employee illness for the facility. She was not provided any type of spread sheet from EH with documentation of employee illness, their symptoms, and their return-to-work date, she was only called with trends that EH noted. Interview on 12/3/25 at 3:07 p.m., with the IP identified she does not monitor if the staff are following through with contacting EH when they are ill as that would be done by management. The manager was to receive an email related to the employee's illness and the manager was responsible to ensure employees followed any return-to-work guidance indicated by EH. She did not oversee employees as part of her surveillance and relied on department managers and EH to ensure staff illnesses were followed. The IP identified she only discussed or brought information to the QAPI meeting related to staff illness if there was something reported from EH, such as an outbreak. She had not brought information related to staff illness to the QAPI meeting. Interview on 12/3/25 at 3:46 p.m., with director of EH identified employees were to contact corporate EH when they were ill. A registered nurse (RN) would manage intakes from staff and was to have gone through an in-depth questionnaire with the employee and make recommendations according to Centers for Disease Control (CDC) and/or the Minnesota Department of Health (MDH). If needed, EH would follow up with staff members. EH was to notify the IP at the facility if they noted a trend or pattern with employee illnesses, but failed to have an ongoing, current method of communication for illness that was not identified to be a pattern or trend. If it was urgent, EH would call the IP directly, otherwise needed communication may be made via a (continued on next page)

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

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	text message or an email. The EH staff were not certified infection preventionists; however, the department did have an infectious disease physician who oversaw the program. The IP communicated any trends and/or patterns of resident illness with EH, to make them aware so they could monitor staff to see if any call-in symptoms correlated with resident illness. EH did not provide any type of surveillance or spreadsheets to the IP. Review of the QAPI minutes from January 2025 through November 2025 identified the IP was bringing overall (but not specific) resident illness reports to QAPI, however, no employee illness data was included in her reports. EH also attended QAPI. In:January, EH noted COVID, RSV and Norovirus continued to be on the rise (unknown if in the community or facility). Any and all illnesses were to be reported to EH.February, EH noted they were seeing staff continue to be positive for COVID and influenza throughout the system. There was no information on what the facility's staff illnesses were, any specific data noted, what goals were, or what action plans were made. March, EH noted staff were not compliance with the influenza vaccine and would be getting an email to complete. The IP noted there was a measles outbreak (unknown if in community or facility). She noted employee health was responsible to monitor audits on employee records on immunity.April, EH had no update. May, employee vaccinations were discussed, but it appeared to be corporate wide and not facility specific, as other states were mentioned in the report of employees. June, EH reported measle rates were increasing in South Dakota, and they were continuing an audit on employee vaccinations. They reported a large drop in employee illness. July, the IP noted an increase in respiratory illness on one unit that past month. EH made no mention of any staff illness, or the data was given to the IP to see if any correlation with resident illness occurred. August, the IP made no mention of any resident illness and EH made no mention of any staff surveillance. September, the IP noted a COVID outbreak began 9/11/25 related to a positive employee. EH noted an increase of respiratory illness among staff and encouraged the employee health line (used to report employee illness) for the return-to-work process and to follow infection control prevention. There was no indication QAPI nor the IP identified the concern with EH lack of delegated oversight in the potential for employees to return to work before being cleared or staff not reporting illnesses. October, EH reported no trends in employee illness, but failed to include any data to identify if enhanced surveillance was required of specific residents having been provided care by staff that were ill or if employees had followed policy and procedures and reported their illness upon onset of symptoms, had been restricted from work, or had specific guidance on when to return to work was appropriate. The IP reported 15 resident infections. Employee health provided no employee illness surveillance. Interview and QAPI review on 12/03/25 at 4:18 p.m. with quality assurance coordinator (QA)-A identified the IP was to give ongoing reports noting resident illness rates for identified infections at least quarterly. QA-A was unable to show evidence the IP was bringing any information forward regarding staff illness or that EH was monitored to ensure they were completed their delegated employee illness responsibilities appropriately. QA-A called the IP to ask if she had any reports from EH related to employee illness. The IP reported if there was a concern with staff illness, such as an outbreak, she could discuss that in QAPI, otherwise she did not bring any information regarding staff illness surveillance to QAPI. Interview on 12/3/25 at 5:15 p.m., with director of nursing (DON) identified the IP attended daily huddles and staff call ins were discussed at that time. She agreed there was a lack of documentation and oversight related to staff illness. She felt the information was there however, there was lack of documentation the IP was receiving and reviewing the information. She confirmed the IP was responsible for oversight of the infection prevention program and that was to include employee/staff surveillance. The undated, System Quality Plan identified management officials were responsible for improvement efforts. There was no mention in the plan of infection control surveillance, how QAPI was to provide oversight of the infection control program, ensure data submitted was analyzed, that appropriate delegation had occurred from the IP to EH, or that the IP provided oversight of EH in their monitoring of staff illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to have a current, ongoing system of surveillance for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that included all staff. This had the potential to affect all 74 residents. Refer to F882 and F868 Findings include: Review of facility infection control surveillance identified only resident illness surveillance had been completed at the facility. Interview on 12/2/25 at 4:10 p.m., with the infection preventionist (IP) identified employee's call central employee health (EH) when ill to report their symptoms, EH then provides the employee general guidelines of when they can return to work. The manager will get a call that the staff called in ill and when they can return to work based on the employee's illness. If employee heath identified a trend in employee illness, then EH would reach out to notify her so she could compare with the facility residents to see if there was any correlation. She revealed that she did not keep a record of employee illness only EH had that documentation. She was responsible for the resident surveillance at the facility and that EH tracked employee illness for the facility. She was not provided any type of spread sheet from EH with documentation of employee illness, their symptoms, and their return-to-work date, she was only called with trends that EH noted. Interview on 12/2/25 at 4:26 p.m., with director of nursing (DON) identified when a staff member called in for a shift the nurse would update the schedule online and then filled out a communication form that was turned into her to file in the employees personal file. Interview on 12/3/25 at 9:43 a.m., with licensed practical nurse (LPN)-A identified when a staff member called in for a shift the nurse filled out a communication form that included the date, the employee's name, and the issue for the call in, and if the staff need to contact EH. The nurse then notified the on-call manager and turned the communication form into the director. Interview on 12/3/25 at 9:45 a.m., with RN-A (the unit supervisor), identified if staff called in for work the nurse would contact her and she would assist with covering the shift. She ensured EH was contacted by the staff member by reaching out to EH herself and she notified HR. If the staff member had a doctor's note she would be responsible for scanning that and sending it to EH. Review of the Communication form (used by the charge nurses to give to the DON with absences from staff), and corresponding facility staff time-punches identified:-Nursing assistant (NA)-A had called in ill on 9/16/25. Staff documented on the communication form, that NA-A was directed by the nurse to contact EH after 8:00 a.m. that morning.-NA-B (who worked the night shift) had called in on 11/15/25, for symptom of diarrhea. Review of her time punches showed NA-B had in fact worked her shift and was not prohibited from work with her symptoms. NA-B also worked the next day on 11/16/25.-NA-C went home ill with symptoms of nausea and vomiting on 11/28/25. NA-C had left during her shift on 11/28/25. There was no indication of when NA-C was allowed to return to work as time punches were requested but not given.There was no mention of resolution of symptoms, if the facility had followed infection control standards for criteria in order to ensure staff were safe to return to work, or if they had been prohibited from work for an appropriate amount of time. Review of the employee health's (EH) staff illness spread sheet (only used by corporate and not available at the facility) identified on: -9/16/25, NA-A had reported to EH symptoms of cough, sore throat, fatigue, diarrhea, and vomiting, which began on 9/15/25. EH had noted NA-A had met criteria to return to work on 9/17/25, although it is unclear what criteria was used to make that determination.-11/15/25, NA-B was not mentioned in the data, and there was no documentation to support NA-B had ever called EH. There was also no indication the IP had followed up to ensure NA-B had followed facility protocol and advised EH of her illness.-11/28/25, NA-C called EH and reported symptoms of shortness of breath, headache, sore throat, runny nose/congestion, fatigue, and muscle aches which began on 11/26/25. EH advised NA-C she would be allowed to work 24 hours after improvement in symptoms and be fever free without use of fever reducing medication. There was no indication NA-C was instructed to call EH back upon improvement or resolution of symptoms to ensure she remained out of work for the appropriate time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/3/25 at 3:07 p.m., with the IP identified she does not monitor if the staff are following through with contacting EH when they are ill as that would be done by management. The manager was to receive an email related to the employee's illness and the manager was responsible to ensure employees followed any return-to-work guidance indicated by EH. She did not oversee employees as part of her surveillance and relied on department managers and EH to ensure staff illnesses were followed. The IP identified she only discussed or brought information to the QAPI meeting related to staff illness if there was something reported from EH, such as an outbreak. She had not brought information related to staff illness to the QAPI meeting. Interview on 12/3/25 at 3:46 p.m., with director of EH identified employees were to contact corporate EH when they were ill. A registered nurse (RN) would manage intakes from staff and was to have gone through an in-depth questionnaire with the employee and make recommendations according to Centers for Disease Control (CDC) and/or the Minnesota Department of Health (MDH). If needed, EH would follow up with staff members. EH was to notify the IP at the facility if they noted a trend or pattern with employee illnesses, but failed to have an ongoing, current method of communication for illness that was not identified to be a pattern or trend. If it was urgent, EH would call the IP directly, otherwise needed communication may be made via a text message or an email. The EH staff were not certified infection preventionists; however, the department did have an infectious disease physician, who oversaw the program. The IP communicated any trends and/or patterns of resident illness with EH, to make them aware so they could monitor staff to see if any call-in symptoms correlated with resident illness. EH did not provide any type of surveillance or spreadsheets to the IP. Interview on 12/3/25 at 5:15 p.m., with director of nursing (DON) identified the IP attended daily huddles and staff call ins were discussed at that time. She agreed there was a lack of documentation and oversight related to staff illness. She felt the information was there however, there was lack of documentation the IP was receiving and reviewing the information. She confirmed the IP was responsible for oversight of the infection prevention program and that was to include employee/staff surveillance. Review of 6/26/25, Infection Prevention Program and Authority policy identified infection preventionist was to implement infection prevention. The IP was to implement appropriate surveillance, prevention, and control measures when conditions exist that may spread and impact residents or employees. The function and duties included identification, maintaining surveillance, analyzing data, and implement corrective actions to minimize infections. Supervision of the infection control program included implementing precautions, hand hygiene, environmental cleaning, reviewing policies and procedures, oversight of surveillance, reporting and evaluation, consultation to staff on cleaning/disinfection procedures, new employee training, referring staff to EH for issues related to blood borne pathogens and staff exposures to those pathogens, tuberculosis (TB) control and the antibiotic stewardship program. A job description for the infection preventionist was requested but not provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate oversight of the infection control (IC) program that included employee surveillance of all employees. This had the potential to affect all 74 residents. Refer to F880 and F868 Findings include: Review of facility infection control surveillance identified only resident illness surveillance had been completed at the facility. Employee surveillance had not been included. Interview on 12/2/25 at 4:10 p.m., with the infection preventionist (IP) identified employee's call central employee health (EH) when ill to report their symptoms, EH then provides the employee general guidelines of when they can return to work. The manager will get a call that the staff called in ill and when they can return to work based on the employee's illness. If employee heath identified a trend in employee illness, then EH would reach out to notify her so she could compare with the facility residents to see if there was any correlation. She revealed that she did not keep a record of employee illness only EH had that documentation. She was responsible for the resident surveillance at the facility and that EH tracked employee illness for the facility. She was not provided any type of spread sheet from EH with documentation of employee illness, their symptoms, and their return-to-work date, she was only called with trends that EH noted. Review of the Communication form (used by the charge nurses to give to the DON with absences from staff), and corresponding facility staff time-punches identified:-Nursing assistant (NA)-A had called in ill on 9/16/25. Staff documented on the communication form, that NA-A was directed by the nurse to contact EH after 8:00 a.m. that morning.-NA-B (who worked the night shift) had called in on 11/15/25, for symptom of diarrhea. Review of her time punches showed NA-B had in fact worked her shift and was not prohibited from work with her symptoms. NA-B also worked the next day on 11/16/25.-NA-C went home ill with symptoms of nausea and vomiting on 11/28/25. NA-C had left during her shift on 11/28/25. There was no indication of when NA-C was allowed to return to work as time punches were requested but not given.There was no mention of resolution of symptoms, if the facility had followed infection control standards for criteria in order to ensure staff were safe to return to work, or if they had been prohibited from work for an appropriate amount of time. Review of the employee health's (EH) staff illness spread sheet (only used by corporate and not available at the facility) identified on: -9/16/25, NA-A had reported to EH symptoms of cough, sore throat, fatigue, diarrhea, and vomiting, which began on 9/15/25. EH had noted NA-A had met criteria to return to work on 9/17/25, although it is unclear what criteria was used to make that determination.-11/15/25, NA-B was not mentioned in the data, and there was no documentation to support NA-B had ever called EH. There was also no indication the IP had followed up to ensure NA-B had followed facility protocol and advised EH of her illness.-11/28/25, NA-C called EH and reported symptoms of shortness of breath, headache, sore throat, runny nose/congestion, fatigue, and muscle aches which began on 11/26/25. EH advised NA-C she would be allowed to work 24 hours after improvement in symptoms and be fever free without use of fever reducing medication. There was no indication NA-C was instructed to call EH back upon improvement or resolution of symptoms to ensure she remained out of work for the appropriate time. Interview on 12/3/25 at 3:07 p.m., with the IP identified she does not monitor if the staff are following through with contacting EH when they are ill as that would be done by management. The manager was to receive an email related to the employee's illness and the manager was responsible to ensure employees followed any return-to-work guidance indicated by EH. She did not oversee employees as part of her surveillance and relied on department managers and EH to ensure staff illnesses were followed. The IP identified she only discussed or brought information to the QAPI meeting related to staff illness if there was something reported from EH, such as an outbreak. She had not brought information related to staff illness to the QAPI meeting. Interview on 12/3/25 at 3:46 p.m., with director of EH identified employees were to contact corporate EH when they were ill. A registered (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nurse (RN) would manage intakes from staff and was to have gone through an in-depth questionnaire with the employee and make recommendations according to Centers for Disease Control (CDC) and/or the Minnesota Department of Health (MDH). If needed, EH would follow up with staff members. EH was to notify the IP at the facility if they noted a trend or pattern with employee illnesses, but failed to have an ongoing, current method of communication for illness that was not identified to be a pattern or trend. If it was urgent, EH would call the IP directly, otherwise needed communication may be made via a text message or an email. The EH staff were not certified infection preventionists; however, the department did have an infectious disease physician who oversaw the program. The IP communicated any trends and/or patterns of resident illness with EH, to make them aware so they could monitor staff to see if any call-in symptoms correlated with resident illness. EH did not provide any type of surveillance or spreadsheets to the IP. Interview on 12/3/25 at 5:15 p.m., with director of nursing (DON) identified the IP attended daily huddles and staff call ins were discussed at that time. She agreed there was a lack of documentation and oversight related to staff illness. She felt the information was there however, there was lack of documentation the IP was receiving and reviewing the information. She confirmed the IP was responsible for oversight of the infection prevention program and that was to include employee/staff surveillance. Review of 6/26/25, Infection Prevention Program and Authority policy identified infection preventionist was to implement infection prevention. The IP was to implement appropriate surveillance, prevention, and control measures when conditions exist that may spread and impact residents or employees. The function and duties included identification, maintaining surveillance, analyzing data, and implement corrective actions to minimize infections. Supervision of the infection control program included implementing precautions, hand hygiene, environmental cleaning, reviewing policies and procedures, oversight of surveillance, reporting and evaluation, consultation to staff on cleaning/disinfection procedures, new employee training, referring staff to EH for issues related to blood borne pathogens and staff exposures to those pathogens, tuberculosis (TB) control and the antibiotic stewardship program. A job description for the infection preventionist was requested but not provided.