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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gil-Mor Manor	96 Third Street East Morgan, MN 56266

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 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 updated, identified an individualized comprehensive care plan

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 [NAME]-[NAME] 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 [NAME]-[NAME] 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