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	07/24/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and document review the facility failed to ensure 1 of 5 residents (R1) had a Consent for Psychotropic Medication Use identifying the risks, benefits, and alternative treatments available. Findings include: R1's 5/30/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was intact, she had no signs of significant depression and displayed no behaviors. R1 had diagnosis of dementia and depression, she was administered an antidepressant on a routine basis and required assistance with activities of daily living (ADL)'s. R1's July 2025, Medication Administration Record identified she was administered citalopram 30 milligrams (MG) by mouth daily for major depressive disorder. Interview on 7/22/25 at 3:12 p.m., with registered nurse (RN)-A identified that the facility was to have the resident or resident representative sign a consent for psychotropic medication use when starting a medication. When an order was obtained for a psychotropic medication, the nurse should be reviewing the consent with the resident and/or representative of the risks and benefits and have the consent signed. She confirmed that R1's consent for use of a psychotropic medication for citalopram (an antidepressant), for the diagnosis of major depressive disorder had not been completed. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator identified they agreed with the above findings and would expect staff to ensure residents' who start a new psychotropic medication would be provided the risks, benefits, and alternative treatments available in writing. Review of the undated, Psychotropic Drug Policy and Procedure identified staff would provide the resident/resident representative with the indication, dose, side effects, adverse consequences and goal of treatment. They would obtain the informed consent, and it would be added to the resident's medical record. The consents would be reviewed quarterly at the resident's care conference.

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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and document review the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) CMS-10055 for 1 of 3 residents (R6) reviewed.Findings include: Review of R6's medical record identified she had received skilled Medicare covered services from 11/3/25 through 2/7/25. Review of R6's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) identified services had been discontinued by the facility prior to benefit days being exhausted. R6 had been notified on 2/6/25 that her coverage would end on 2/7/25. Interview on 7/22/25 at 2:13 p.m., with registered nurse (RN)-A identified she was responsible for providing the non-coverage notices to residents and had missed the deadline for providing the notice. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator agreed with the above findings and identified it was their expectation that staff would ensure the SNFABN notices would be provided no later than 2 days prior to the last covered day. Review of the 12/18/19 Issuing the NOMNC and SNFABN policy identified the SNFABN must be served to the beneficiary or person acting on the beneficiary's behalf no less than 48 hours (2 days) in advance. A progress note was to be recorded in the medical record when serving these notices.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and document review the facility failed to have 2 of 6 residents (R4, R11) assessed by a physician for need to continue taking an as needed antianxiety medication. Findings include: R4R4's 7/22/25, quarterly Minimum Data Set (MDS) assessment identified R4's cognition was intact and required minimal assistance with cares. R4 took an antianxiety and antidepressant medication. R4's 7/23/25, Medical Diagnosis list identified anxiety disorder, chronic obstructive pulmonary disease with exacerbations, pulmonary emphysema, major depressive disorder, alcohol dependence with alcohol induced anxiety disorder, and chest pain. R4's 7/23/25, Order Summary Report identified an order for Ativan 0.25 milligrams (MG) every 24 hours as needed (PRN) for anxiety started on 4/4/25. R4's 7/1/25, physician visit notes made no mention of a rationale for continued use of her Ativan PRN medication, or review of how often she was needing the medication and if it was effective and there was no documentation to support the physician had reviewed or renewed the Ativan PRN order since 4/4/25. R4's pharmacy reviews from April 29th, 2025, through July of 2025 all identified that a chart review had been completed with no concerns or recommendations. There was no indication that the pharmacist identified there was no end date or review date identified for the Ativan PRN order that had been initiated on 4/4/25. R11R11's 6/20/25, quarterly MDS assessment identified R11's cognition was moderately impaired, and she required extensive assistance with cares. R11 took an antianxiety medication. R11's 7/23/25, Medical Diagnosis list identified a diagnosis of anxiety disorder. R11's 7/23/25, Order Summary Report identified an order for clonazepam (Klonopin) 0.25 mg every 12 hours PRN started on 11/7/24. R11's 5/20/25, physician visit notes made no mentioned of a rationale for continued use of her Klonopin PRN medication or review of how often she was needing the medication and if it was effective and there was no documentation to support the physician had reviewed or renewed the Klonopin PRN order from 11/7/24 to present. R11's pharmacy reviews from November 2024 through July of 2025 all identified that a chart review had been completed with no concerns or recommendations. There was no indication that the pharmacist identified there was no end date or review date identified for the Klonopin PRN order from 11/7/24 Interview on 7/22/25 at 3:12 p.m., with registered nurse (RN)-A identified R4 and R11's psychotropic PRN medications should have been re-assessed every 14 days unless the provider otherwise documented a rationale for use and an extended re-assessment time frame. RN-A felt the charge nurses knew psychotropic PRN medications need to be assessed every 14 days and was unsure why that had not occurred. She would be working on a new system to ensure that was occurring. Interview on 7/23/25 at 12:02 p.m., with consulting pharmacist (RPh) identified she reviewed as-needed medication while completing her monthly review. The RPh confirmed R4 had an order for Ativan PRN. R11 had started Klonopin PRN medication in November 2024. She typically checked psychotropic medications every 6 months and then yearly to see if there needed to be a dose change. The RPh confirmed neither R4 or R11 had a review that she could find since starting the psychotropic PRN medication. When a resident was on a psychotropic PRN medication, she would notify the facility a 14-day assessment needed to be completed. The RPH did not notify the provider of the need, but she did notify the facility, and they were expected to make sure it had been completed. Interview on 7/23/25 at 5:15 p.m., with director of nursing (DON) and administrator identified their expectation was all psychotropic PRN medications would be re-assessed by a physician every 14 days or have a documented rationale for continued use if an extended re-assessment timeframe was to occur. A policy on psychotropic as needed medications was requested but not provided by end of survey.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and document review the facility failed to ensure emergency medications stored in 1 of 1 medication storage room were not expired.Findings include: Observation and interview on 7/23/25 at 12:33 p.m., with licensed practical nurse (LPN)-A of the medication room identified the emergency medication kit (E-kit) was observed sitting on the counter. On the top of the E-kit a sticker was observed that said exp (expiration) 6/27. LPN-A was not certain if that meant the medications in the E-kit expired on 6/27/25 or June of 2027. Observation of the medications inside the E-kit identified 2 Morphine filled syringes 4 milligrams/milliliter (mg/mL). The manufacturers expiration date printed on the syringe was June of 2025. In addition, there were several other medications that had printed medication expiration dates that were listed as expired and handwritten expiration dates that were listed as not expired. LPN-A agreed the medications listed were expired. She was not certain which date they were to use to determine if the medication was expired. Interview on 7/23/25 at 3:31 p.m., with the pharmacy contact person agreed the 2 morphine pre-filled syringes were expired. She identified the printed expiration dates on the other medications were for the prescription and the handwritten expiration dates were for the medications. She agreed it was unclear on the label but stated the staff are aware. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator identified they agreed with the above findings. They would have expected the pharmacy to remove the expired medications from the E-kit to avoid the potential administration of the outdated medications. In addition, they agreed that the expiration dates noted on the other medications in the Ekit were not clearly identified. A policy was requested but nothing was provided by the end of the survey period.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Base on interview and document review, the consulting pharmacist (RPh) failed to identify irregularities for 3 of 8 sampled residents (R4, R11, and R28) reviewed. Findings include: R4R4's 7/22/25, quarterly Minimum Data Set (MDS) assessment identified R4's cognition was intact, and she required minimal assistance with cares. R4 took an antianxiety and antidepressant medication. R4's 7/23/25, Medical Diagnosis list identified anxiety disorder, chronic obstructive pulmonary disease with exacerbations, pulmonary emphysema, major depressive disorder alcohol dependence with alcohol induced anxiety disorder, and chest pain. R4's 7/23/25, Order Summary Report identified the following order: Ativan 0.25 milligrams (MG) every 24 hours as needed (PRN) for anxiety started on 4/4/25 with no identified end date. R4's pharmacy reviews from April 29th, 2025, through June of 2025 all identified that a chart review had been completed with no concerns or recommendations. There was no indication the pharmacist identified or recommended a follow up with the provider as there was no end date or review date identified for the Ativan PRN order initiated on 4/4/25. R11R11's 6/20/25, quarterly MDS assessment identified R11's cognition was moderately impaired, and she required extensive assistance with cares. R11 took an antianxiety medication. R11's 7/23/25, Medical Diagnosis list identified an anxiety disorder and hypertension. R11's 7/23/25, Order Summary Report identified an order for Clonazepam (Klonopin) 0.25 mg every 12 hours PRN started on 11/7/24 with no identified end date. R11's pharmacy reviews from November 2024 through June of 2025 all identified a chart review had been completed with no concerns or recommendations. There was no indication that the pharmacist identified or recommended a follow up with the provider as there was no end date or review date identified for the Klonopin PRN order that had been initiated on 11/7/24 R28R28's 2/6/25, quarterly MDS assessment identified R28 cognition was intact, and he required extensive assistance with cares. R28 took an antibiotic, diuretic, and opioid medication. R28's 7/23/25, Order Summary Report identified the following order Minocycline HCl 100 mg every evening for infection and inflammatory reaction due to internal right knee prosthesis started on 1/13/23 with no identified end date. R28's pharmacy reviews from January 2025 through June 2025, all identified a chart review had been completed with no concerns or recommendations except for the month of March. In March there was a recommendation made for a dose reduction, if appropriate, for omeprazole 20 mg (a stomach acid reducer) as the resident had been on the since 2022. There was no indication the pharmacist identified or recommended a follow up with the provider as there was no end date or review for continued need for the Minocycline HCl order that was initiated on 1/13/23. Interview on 7/23/25 at 12:02 p.m., with the RPh identified she reviewed the as needed (PRN) psychotropic medication and antibiotics during her monthly review. If there was no identified end date or review date, she would make a recommendation to the facility to follow up on that. She confirmed R4 and R11 had not been reviewed for their PRN psychotropic medications and that R28 was on an antibiotic that had been ordered back in 2023, with no re-assessment she was aware of for continued need for use. When identified, she would make a recommendation to the facility to follow up on the concern. Interview on 7/23/25 at 5:15 p.m., with the director of nursing (DON) and the administrator identified they have a contract with the pharmacy. Their expectation was any identified irregularities, such as no end dates on a PRN psychotropic medication or an antibiotic that had been in place for an excessive amount of time, be brought to the facility for attention to review. They would expect any findings and recommendation to be documented for the facility to have documentation to ensure the recommendations were acted upon. Review of the 12/5/05, pharmaceutical consultant contract identified RPh would complete a monthly review of each resident's medication orders. The RPh was to review the residents' orders and medical record for potential irregularities and would provide the facility with a written report of identified irregularities, potential problems, or concerns.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review the facility failed to assess the need for continued use of an antibiotic for 1 of 5 sampled residents (R28) reviewed for antibiotic use. Findings include: R28's 2/6/25, quarterly MDS assessment identified R28 cognition was intact, and required extensive assistance with cares. R28 took an antibiotic, diuretic (fluid pill), and opioid (narcotic pain medication). R28's 7/23/25, Order Summary Report identified the following order Minocycline HCl 100 mg every evening for infection and inflammatory reaction due to internal right knee prosthesis started on 1/13/23 with no identified end date. Interview on 7/22/25 at 2:20 p.m., with the infection preventionist (IP) identified she was unaware and surprised that R28 was on an antibiotic that had been ordered back in 2023 and would be addressing that today. She was unaware the medication had been in place and did not believe anyone had assessed the need for continued use. The charge nurse usually gave all the antibiotics and somehow, R28's antibiotic was on the medication cart for the trained medication aide (TMA) to give. The charge nurse typically kept her updated on who was currently taking an antibiotic and since they were not giving it, she thought that was why it was missed for review. Interview on 7/23/25 at 12:02 p.m., with consulting pharmacist (RPh) identified R28 was on an antibiotic that had been ordered back in 2023 with no reassessment that she was aware of for continued need. R28 also had some skin issues, and the antibiotic was probably helpful for that. It was not uncommon to be on Minocycline HCl long term. If there was no end date on an antibiotic order, if noticed, she would bring that to the facilities attention for follow up to see if the medication was still needed. Interview on 7/23/25 at 5:15 p.m. , with director of nursing (DON) identified R28's antibiotic order of Minocycline from 2023 should not have been overlooked that long. She would expect orders were being reviewed by the nurse, the RPh and the provider. There should not be any residents on an antibiotic for excessive duration without a provider assessing the continued need. The facility missed that, and we corrected that today and will be implementing a new process. Review of the undated, Antibiotic Stewardship policy identified the facility would provide efforts to optimize the use of antibiotic in order to maximize their benefits while minimizing resistance as well as adverse side effect. All antibiotic orders would include the diagnosis, medication, dose, route, and duration. Prophylactic antibiotic medication use in the facility would be limited based on the physician documentation of rationale, risks, and benefits for use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review the facility failed to ensure 1 of 1 emergency kit had been secured to avoid the potential for drug diversion.Findings include: Observation, interview, and document review, on 7/23/25 at 12:33 p.m., with licensed practical nurse (LPN)-A of the medication room. The emergency medication kit (E-kit) was observed sitting on the counter. It had a black zip-tie secured on the closure. Over the black zip tie, was a red zip tie with a number (normal use secured latch) on it that was loosely placed. LPN-A pulled the tail of the red numbered zip tie, and it pulled from the E-Kit closure without being cut. LPN-A identified she was not aware why the red numbered zip tie was not securely placed on the E-kit, as it was facility policy the Ekit was to remain locked with the red zip tie and checked at each shift change to ensure the Ekit was appropriately locked and secured. The number on the zip tie matched the number documented in the Ekit count book. LPN-A noted this process was used to avoid the risk of potential drug diversion. A count of the E-kit was completed, and all medications were present. Interview on 7/23/25 at 5:15 p.m., with the director of nursing and administrator identified they agreed with the above findings and would expect staff to ensure the Ekit was properly secured at each shift change. If nursing should find the kit unsecure, the director of nursing and administrator should be notified immediately. Review of the 2/2/20, E-Kit Instructions policy provided by the facility identified the E-kit would be secured with a red numbered zip tie. The number would be recorded in the E-kit count book and would be checked at each shift change with 2 licensed nurses.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to have a thorough, ongoing infection control surveillance program that included resolution of symptoms and/or if any transmission-based precautions (TBP) had been implemented during 3 of 3 months reviewed (April, May, and June of 2025). The facility also failed to identify when employees would be able to return to work after having signs and symptoms of potential Norovirus for 8 of 8 staff (Cook-A, nursing aide (NA)-A, Cook-B, dietary (aide)-A, trained medication aide (TMA)-A, the infection preventionist (IP), NA-B, and TMA-B) reviewed for January of 2025.Findings include: Resident SurveillanceReview of resident surveillance for April, May, and June of 2025, identified a form included the wing of the facility, resident name, and the onset date. The form also listed resident diagnoses of urinary tract infection, lower respiratory infection, upper respiratory infection, skin, blood, gastrointestinal infection, Foley catheter, Other, and fever. There was a place to document signs and symptoms, mental status change, identified organism, X-ray, treatment and dates, and the resolved date. The form had no place to document if any TBP had been implemented or removed or what the resolution date was or if there had been a need to alter treatment. Review of undated, Infection Surveillance policy identified prevention started with routine and ongoing surveillance to identify possible outbreaks and infections before they can spread to others. The facility would establish a system for collecting, analyzing and interpretation of the data to identify infections, risks and outbreaks. Interview on 7/22/25 at 2:20 p.m. with the IP identified she confirmed she had not been documenting a resolution date or had been identifying if a resident was placed on precaution or not on her surveillance.Staff surveillanceReview of staff call in log for January, February, and March of 2025, identified a form the facility was using included an area to document, the report date, employee, vomiting, fever, diarrhea, jaundice, cough/sore throat/runny nose, infected skin lesions, fatigue/body aches, Comments or Other symptoms, date returned to work, and if they had notified the Minnesota Department of Health (MDH). Review of the month of January 2025, identified 8 staff with potential signs and symptoms of Norovirus: Dietary (cook)-A called in on 1/3/25, with vomiting and diarrhea and returned to work on 1/5/25, 2 days later.Nursing assistant (NA)-A called in on 1/7/25 with vomiting and returned to work on 1/8/25, 1 day later.Cook-B called in on 1/8/25 with vomiting and returned to work on 1/9/25, 1 day later.Dietary (aide)-A called in on 1/9/25 with vomiting and returned to work on 1/11/25, 2 days later.Trained medication aide (TMA)-A called in on 1/12/25 with vomiting and returned to work on 1/13/25, 1 day later.Infection preventionist called in on 1/16/25 with vomiting and diarrhea and returned to work on 1/17/25, 1 day later. NA-B called in on 1/22/25 with diarrhea and returned to work on 1/23/25, 1 day later.TMA-B called in on 1/24/25 with diarrhea and returned to work on 1/26/25, 2 days later. Interview on 7/22/25 at 2:20 p.m. with the IP identified staff had Norovirus back in January 2025, but no residents got sick. She agreed staff with signs and symptoms of Norovirus should have been out for a minimum of 48 hours after symptoms resolved according to the facility policy and the Norovirus reported to the MDH. When asked why she returned to work, she reported she did not think she had norovirus but that had not been confirmed by a physician. Continued interview on 7/23/25 at 10:30 a.m., with the IP identified no staff had confirmed norovirus, but she suspected it related to the signs and symptoms staff were calling in for. Staff were not allowed to return to work unless they had been symptom free for 24 hours without medication use. The IP was unaware the MDH required all staff with direct patient care duties, and duties for preparing and serving food were to be kept off work until 72 hours after all symptom resolution. Interview on 7/23/25 at 5:15 p.m., with the director of nursing identified her expectation was that staff followed the facilities policies and procedures for infection control surveillance and for staff illness and return to work. Review of the undated, Employee Illness policy identified examples of possible work restrictions for health care workers, that instructed the facility to contact their state department of health for clarification on work restriction. The policy identified employees with symptoms consistent with Norovirus infection, stay home for a minimum of 48 hours after symptom resolution. There was no indication the policy was reviewed for accuracy. Review of the 2024-2025, Minnesota Department of Health Norovirus information for Long-term care facilities, located at: https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/ltcfnorotoolkit.pdf identified, common symptoms of Norovirus were diarrhea, vomiting, nausea, abdominal pain, low-grade fever, headache, and body aches. By Minnesota state law ([NAME]. Rules part 4605.7050), any pattern of cases, suspected cases, or increased incidence of any illness beyond the expected number of cases in a given period shall be reported

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to complete a comprehensive assessment for continued use of antibiotics for 2 of 3 (R1 and R17) sampled residents reviewed for antibiotic stewardship. Finding include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an antibiotic time-out [ATO]. Review of the monthly resident surveillance for April 2025 through June 2025 identified columns to document location within the facility, resident name, onset date, type of illness, signs and symptoms, mental status changes, organism, treatment and dates, resolution, and comments. However, the log lacked evidence that the antibiotic had met criteria for continuation of use. Review of the April 2025, resident surveillance log identified R1 had been prescribed Azithromycin (Z-Pack) antibiotic medication 500 milligrams (mg) on day one, then 250 mg twice a day for 4 days. The onset of the infection occurred on 4/8/25 and lacked indication of an antibiotic assessment (time-out) 48-72 hours after starting to determine criteria met for continuation of use. Review of the June 2025, resident surveillance log identified R17 had been prescribed Doxycycline 100 mg twice a day for 10 days. The onset of the infection occurred on 6/3/25 and lacked indication of an antibiotic time-out for continued use. R1's medical record had no mention that R1 had been assessed to be determined if the antibiotic was appropriate or effective. There was no indication of communication with the provider after starting the antibiotic. R17's medical record did identify in the progress notes assessment of R17's respiratory tract infection that included temperature, oxygens saturation level, antibiotic, and if signs or symptoms improved or not. However, the medical record lacked identification of communication with the medical provider regarding the assessment. Review of the monthly resident surveillance for April 2025 through June 2025 identified columns to document location within the facility, resident name, onset date, type of illness, signs and symptoms, mental status changes, organism, treatment and dates, resolution, and comments. However, the log lacked evidence that the antibiotic had met criteria for continuation of use. Review of the April 2025, resident surveillance log identified R1 had been prescribed Azithromycin (Z-Pack) antibiotic medication 500 milligrams (mg) on day one, then 250 mg twice a day for 4 days. The onset of the infection occurred on 4/8/25 and lacked indication of an antibiotic assessment (time-out) 48-72 hours after starting to determine criteria met for continuation of use. Interview on 7/23/25 at 2:18 p.m., with the administrator identified that the facility had concern with the providers not responding to the antibiotic time-outs, but the facility had not addressed the concern with the medical director or at the QAPI meetings. Interview on 7/23/25 at 5:15 p.m., with director of nursing (DON) identified her expectation was that antibiotic stewardship monitoring was being completed with each antibiotic that was started. Review of undated, Antibiotic Stewardship identified when a resident was suspected to have an infection the facility will communicate assessment findings to the practitioner using McGeer Criteria. If an antibiotic was prescribed the documentation would include diagnosis, medication, dose, route, and duration. The policy had no mention of an antibiotic assessment (time-out) 48-72 hours after starting to determine criteria met for continuation of use.

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	07/24/2025

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 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. (continued on next page)

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 1 infection control preventionist (IP) had provided oversight of the infection control program and the antibiotic stewardship program.Findings include: Review of monthly resident surveillance for April 2025 through June 2025, identified columns to document location within the facility, resident name, onset date, type of illness, signs and symptoms, mental status changes, organism, treatment and dates, resolution, and comments. The form lacked a column for antibiotic time-out and/or if precautions were implemented. The form was not completed in full as the resolved date had not been identified and documented. Review of monthly staff surveillance for January 2025 through March 2025 identified columns to document call in date, employee, vomiting, fever, diarrhea, jaundice, cough/sore throat/runny nose, infected skin lesions/ fatigue/body aches, comments or other symptoms, date returned to work, notified health department. The surveillance identified 8 staff that returned to work prior to the recommended work restrictions for potential symptoms of norovirus. Interview on 7/23/25 at 10:30 a.m., with infection preventionist (IP) identified she was unsure how she provided oversight. She documented staff call-ins and symptoms that the staff reported to her. However, the charge nurse was supposed to be completing a call-in form but that had not been getting completed like it was supposed to. For resident surveillance, she reported she reviewed the 24-hour report upon arrival and if a resident had been started on an antibiotic she would go to the chart and review the documentation. For residents who were ill but not on an antibiotic, that information would be documented in the resident progress notes. She only documented residents on antibiotics on the monthly resident surveillance form. She revealed she had no documentation of any follow up for protocols not being followed. There was not an effective process in place to for providing oversight of the programs. Interview on 7/23/25 at 5:15 p.m., with the director of nursing (DON) identified her expectation was that the IP would be providing oversight of both the infection control program and the antibiotic stewardship program. The IP should be monitoring and ensuring the policies and protocols are being followed and if not, educate and implement a plan to correct why not being followed. The DON was unaware the IP was not performing her duties as required. Review of the 2020, Infection Prevention and Control Manual-Infection Surveillance Overview policy identified the intent of surveillance is to identify possible communicable diseases or infections before they can spread to other persons in the facility. In addition, Surveillance is crucial in the identification of possible clusters, changes in prevalent organisms, or increases in the rate of infection promptly. The results should be used to plan infection control activities, direct in-service education, and identify individual resident problems in need of intervention.1.The Infection Preventionist (IP) was to collect and review data on an ongoing basis including:elevations in temperatures/presence of fever,purulent drainage,culture results or other diagnostic test results consistent with potential infections,change in X-ray results consistent with possible infection,increased falls,changes in mental status,changes in vital signs,signs and symptoms of infection based upon nationally accepted surveillance definitions (i.e. CDC/[NAME] Position Statement: Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria or NHSN).2. The Infection Preventionist will ensure data collection to complete a comprehensive Monthly Infection Control Log for surveillance activities on:The infection sitePathogen (if known)Signs and SymptomsResident LocationSummary and Analysis of number of residents and/or staff with infectionsObservations of staff adherence to policies and proceduresIdentification of outcomes that are unusual or unexpected that could potentially lead to patterns, trends or outbreaks 3. The Infection Preventionist and the Infection Prevention and Control Committee were to utilize the information collected from both Process and Outcome Surveillance activities in order to calculate rates and analyze the data to identify opportunities for improved care and process and identify an action plan for follow up and corrective action and reporting.Findings are summarized and reported to the Infection Control (IC) oversight committee and departments that were observed. If indicated, a Performance Improvement Project will be identified and included as part of the QAPI process. A summary of results will be identified to the Quarterly OAA Committee. There was no indication the IP was being overseen by an IC committee.