Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 26, 2024

Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: CCN: 245489
Cycle Start Date: December 18, 2024

Dear Administrator:

On December 18, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 18, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 18, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/16/24, to 12/18/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/16/24 to 12/18/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiency issued: H54891497C (MN00105011). H54891584C (MN00097928). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 01/02/2025

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.

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) (refers to how far you can move or stretch a part of your body) services to prevent a potential decrease in range of motion for 1 of 1 resident (R21) reviewed who required range of motion for restorative nursing exercises. Findings include: R21's annual Minimum Data Set (MDS) dated	F 688	Tag: F688 Increase/Prevent Decrease in ROM/Mobility Corrective action to resident found to be affected: Therapy evaluation done on (R21) on 12/18/24. ROM program initiated and placed in PCC for documentation to be completed. How the facility identified other residents' potential to be affected: Audit done on	1/20/25

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F 688	Continued From page 2 10/30/24, indicated R21 was cognitively intact. R21 had a diagnoses which included hemiplegia (a condition caused by brain damage that leads to paralysis on one side of the body,) cerebral infarction affecting the left non-dominant side (stroke), heart failure, and hypertension (high blood pressure). R21 required extensive assistance with bed mobility, transfers, and toileting. R21's Significant Change Care Area Assessment (CAA) dated 10/30/24, indicated R21 was able to voice concerns and preferences and make daily choices. R21 required extensive assistance with activities of daily living (ADLs) which included dressing, bed mobility, and transfers. R21's current care plan revised 8/2/24, revealed restorative nursing program in place as directed, initiated on 3/3/3017, and revised on 8/2/24. ROM provided with morning (AM) afternoon (HS) cares (activities of daily living), Date initiated 3/11/24. During the review of Occupational Therapy (OT) evaluation and plan of treatment dated 2/27/24-5/26/24, revealed R21's musculoskeletal system assessment identified the right upper extremity range of motion was within normal limits. Left upper extremity was impaired. Lower right extremity was within normal limits. Left lower extremity was impaired. During the review of nursing assistant care sheets titled team two, dated 12/18/2024, indicated R21 was to receive range of motion with AM/HS cares. During an interview on 12/16/24 at 1:22 p.m., R21 indicated staff stopped the range of motion	F 688	other residents to assure ROM was implemented and put in PCC for staff completion. Measures put in place to ensure it will not recur: Education to NAR's and Nurses on ROM and where to document in PCC. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits, it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Nurses/RN Managers/Director of Nursing/Therapy/designee Date of completion: 1/20/25	

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F 688	Continued From page 3 restorative program about two years ago. R21 indicated it would have been nice to have stretching, especially on his knee. R21 stated his knee had an increase in stiffness. R21 indicated he talked to staff about wanting to have stretching done however range of motion was not being completed daily. During an interview on 12/17/24 at 2:24 p.m., nursing assistant (NA)-C indicated R21 did not have a ROM program in place. NA-C stated R21 never had a ROM program. NA-C indicated she had received training on ROM and restorative programs in the past. During an interview on 12/17/24 at 2:38 p.m., NA-F indicated R21 did not have a restorative program or ROM with cares. During an interview on 12/17/24 at 3:56 p.m., the occupational therapy assistant indicated therapy recommended range of motion to be completed by nursing staff when R21 was getting dressed. It was not added for additional care however should have been incorporated with activities of daily living (ADLs). During an interview on 12/17/24 at 2:46 p.m., registered nurse (RN)-B indicated R21 had a ROM program in the morning and evening when getting dressed. RN-B indicated she had worked with R21 since he was admitted and R21 had always had a ROM program. . During an interview on 12/17/24 at 2:58 p.m., clinical manager indicated R21 was cognitively intact however does have some recall issues such as what he ate for supper last night. The clinical manager indicated ROM was to be	F 688		

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F 688	Continued From page 4 completed with morning and evening cares. The clinical manager revealed she was in charge of making sure ROM was completed. The clinical manager revealed in the past ROM was a task on the computer that staff would chart when it was finished. The task was removed to save time when charting. The clinical manager indicated ROM for R21 was care planned under ADLs and was care planned on 3/11/24. The clinical manager verified that R21 had a restorative ROM program. Clinical manager indicated nursing assistants should have been completing the ROM program with morning and evening cares. The clinical manager stated ROM was important due to stroke, and a potential for increase of contractions if the tasks were not completed. The clinical manager would expect staff to perform his ROM and report if he refused. During an interview on 12/17/24 at 3:37 p.m., registered nurse (RN)-A, was unsure if R21 had a ROM program. During an interview on 12/18/24 at 7:10 a.m., NA-H indicated she was not aware if R21 had a restorative program. During an interview on 12/18/24 at 8:44 a.m., licsensed practical nurse (LPN)-C was unsure if R21 had a ROM program. During an interview on 12/18/24 at 8:50 a.m., NA-B indicated she was trained in ROM and restorative programs. NA-B indicated all residents were supposed to have ROM exercise completed. NA-B indicated she had worked as a restorative aid and completed ROM on all residents. NA-B reported she no longer worked as a restorative aid as that program was stopped	F 688		

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F 688	Continued From page 5 and now all nursing assistants were expected to perform ROM. During an interview on 12/18/24 at 8:57 a.m., physical therapist looked at R21's care plan on the computer and verified that R21 had a ROM program. Upper extremities stretching for five seconds counts in the morning, and the afternoon shift to do ROM on the lower extremities. The Physical Therapist indicated ROM was important for R21, especially for his left arm. The physical therapist would expect staff to perform ROM at least in the morning. During an interview at 12/18/24 9:03 a.m., the Rehab and therapy director (RTD) indicated that if there was a change in R21's condition, therapy would do an evaluation. Nurses were expected to communicate with the therapy department if there was an issue, such as residents becoming more stiff or declining in function. Based on the evaluation, R21 would start therapy, or have nursing continue with the ROM program. If the ROM was not getting done, nursing staff were expected to communicate that with the therapy department. The RTD reported the therapy department did not have time to follow ROM programs. The RTD indicated therapy would have to completed an assessment while R21 was in bed to see if there had been a change with R21's ROM. RTD stated ROM was important to maintain a residents ability to sit or stand and have less muscle contractors. RTD indicated staff completing ROM on R21 would assist in maintaining R21's joint integrity. During an interview on 12/18/24 at 9:20 a.m., director of nursing (DON) indicated when a resident was discharged from therapy, ROM was	F 688		

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F 688	Continued From page 6 added to the care plan for the nursing staff to complete. DON reported that R21 did have ROM in the care plan. DON expected staff to follow the care plan. DON stated ROM was important to prevent a decline and contractures. DON stated if a resident refused ROM it should have been documented and reported. During a follow-up interview and observation on 12/18/24 at 11:04 a.m., RTD entered R21's room to assess R21's ROM. R21 was lying down in bed and stated his knee had become more stiff, however denied pain. RTD performed ROM and completed an assessment. The RTD stated there was no decrease in ROM and no change in ROM. RTD recommended that staff would complete ROM daily. A policy titled Restorative Nursing Services dated 2001 revealed Residents would receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consisted of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational, or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative cares. Restorative goals and objectives were individualized and resident-centered, and were outlined in the resident's plan of care. A policy titled Resident Mobility and Range of Motion dated 2001 revealed residents would not experience an avoidable reduction in range of motion (ROM). Residents with limited range of motion would receive treatment and services to	F 688		

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F 688	Continued From page 7 increase and/or prevent a further decrease in ROM. Documentation of resident's progress toward the goals and objectives would include attempts to address any changes or decline in the resident's condition or needs. .	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess and implement safe smoking interventions for 1 of 1 resident (R6) reviewed for smoking. Findings include: R6's quarterly Minimum Data Set (MDS) dated 10/23/24, indicated R6 had diagnoses which included diabetes mellitus (DM), anemia (a condition where there are lower than normal number of red blood cells in the body), and hypertension (elevated blood pressure). Identified R6 had intact cognition and required extensive assistance from staff with activities of daily living	F 689	Tag: F689 Free of Accident/Hazard/Supervision/Devices Corrective action to resident found to be affected: R6 was provided a smoking apron, and an updated smoking assessment was completed on 12/20/2024, assuring safety while smoking. How the facility identified other residents' potential to be affected: Audit done to assure no other residents are at risk for unsafe smoking.	1/20/25

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F 689	Continued From page 8 (ADL's) which included transfers and toileting. R6's significant change in status Care Area Assessment dated 6/6/24, identified interventions were in place to address safety needs. R6's care plan dated 4/11/24, identified the facility had determined R6 was safe to smoke independently. Care plan identified a goal that R6 refrained from smoking in inappropriate places. R6's smoking assessment dated 4/11/24, indicated R6 was safe to light the cigarette, extinguish and dispose of cigarette safely. Assessment indicated R had not required a smoking apron and was safe to smoke without supervision. Assessment lacked information regarding burns on R6's clothing R6's smoking assessment dated 10/25/24, indicated R6 was safe to light the cigarette, extinguish and dispose of cigarette safely. Indicated R6 was to bring the cigarette butt to disposal at front entrance of the facility. Assessment further indicated R had not required a smoking apron and was safe to smoke without supervision. Assessment lacked information regarding burns on R6's clothing. Review of R6's clothing log titled closet items with burn holes in them dated 10/25/24 identified one blue and gray shirt, black jacket with 16 holes, flannel shirt, black ling sleeve shirt, three tank tops, see through black and white shirt, and a 3/4 sleeve shirt. During an interview on 12/16/24 at 12:55 p.m., R6 stated she was a smoker and the facility stored her cigarettes and lighter for her. R6 stated she	F 689	Measures put in place to ensure it will not recur: Education to all nursing staff on new intervention for R6 and the reviewed the smoking policy. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits, it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Nurses/RN Managers/Director of Nursing/Therapy/designee Date of completion: 1/20/25	

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F 689	Continued From page 9 did not need a smoking apron and was able to go outside by herself off the facility grounds to smoke. During an observation on 12/16/24 at 1:05 p.m., R6 was seated in her electric scooter at the nurses station wearing a black winter jacket which contained several burn holes in the front of the jacket. R6 stated the holes were from smoking however the jacket was an old jacket from prior to her admission to the facility. R6 received a case with hand rolled cigarettes and a lighter from licensed practical nurse (LPN)-A. R6 proceeded outside and down the hill in her electric scooter. R6 proceeded approximately one block down the road before stopping on the street near an apartment building. R6 removed a rolled cigarette from the case and used the lighter to light the cigarette. As R6 began smoking the cigarette ashes began falling onto her pants. R6 had not made any effort to remove the cigarette ashes from her pants and continued smoking. R6 used her index finger on her left hand to flip the cherry off of the cigarette onto the ground and placed the paper from the cigarette into the case with the other cigarettes. R6 then removed another cigarette from the case and lit the cigarette with the lighter. As R6 began smoking the cigarette ashes fell onto her pants. R6 made no effort to remove the ashes from her pants and continued smoking. R6 used her index finger on her left hand to flip the cherry off of the cigarette onto the ground and held the paper from the cigarette in her left hand. R6 proceeded back up the hill in her electric scooter and placed both the paper in her hand and the one she had placed in the case into the cigarette receptacle which was located approximately 200 feet from the front entrance of the building.	F 689		

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	245489	A. BUILDING _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 689	Continued From page 10 During an observation on 12/17/24 at 8:35 a.m., nurse manager (NM)-A was standing outside at the top of the hill next to a cigarette receptacle while R6 was smoking a cigarette. During an interview on 12/17/24 at 9:08 a.m., laundry supervisor (LS) stated she had noticed several burn holes in R6's black winter jacket about two weeks ago when she washed the jacket. LS indicated she had not seen burns in any of R6's other clothing that had come down to be washed. During an interview on 12/17/24 at 11:00 a.m., nursing assistant (NA)-A stated R6 was a smoker and the nurses stored R6's cigarettes for her. NA-A stated R6 was able to smoke without supervision or a smoking apron. NA-A stated she had noticed at least one burn hole in R6's black winter jacket about a month or so ago. During an interview on 12/17/24 at 9:44 a.m., NA-B stated R6 was a smoker and the nurses stored R6's cigarettes for her. NA-A stated R6 was able to smoke without supervision or a smoking apron. NA-A stated she had noticed several burn holes in R6's black winter jacket about a month ago. During an interview on 12/17/24 at 11:02 a.m., LPN-B stated R6 was a smoker and the nurses stored R6's cigarettes for her. LPN-B stated R6 was able to smoke without supervision or a smoking apron. LPN-B stated she had noticed several burn holes in R6's black winter jacket about a month ago. During an observation on 12/17/24 at 12:35 p.m.,	F 689		

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F 689	Continued From page 11 R6 was sitting in her electric scooter at the nurses station wearing a black jacket with contained several burn holes. R6 received a pack of cigarettes which contained hand rolled cigarettes and a lighter from LPN-A. R6 proceeded outside in her electric scooter to the top of the hill near the cigarette receptacle. As R6 lit her cigarette several ashes fell onto her jacket. R6 made no attempt to remove the ashes and continued smoking. R6 extinguished the cigarette out on the side of the cigarette receptacle and placed the paper from the cigarette into the receptacle and proceeded back into the building in her electric scooter. During an interview on 12/17/24 at 3:16 p.m., clinical manager (CM)-A stated she had become aware of the holes in R6's jacket and clothes when she did R6's smoking assessment on 10/25/24. CM-A stated R6 had told her the holes in her clothes and jacket happened prior to her admission to the facility. CM-A stated she had not considered having R6 use a smoking apron and now feels it may be a good idea because of the history of R6 burning her clothing while smoking. CM-A stated the facility had ordered R6 a smoking apron. CM-A indicated she had moved the cigarette receptacle and smoking area so that it was closer for R6 and so she would be able to safely extinguish her cigarettes. During an interview on 12/17/24 at 3:38 p.m., director of nursing (DO) stated she had been aware of the holes in R6's jacket and clothing since 10/25/24. DON stated the cigarette receptacle was moved closer for R6 so she was able to safely extinguish her cigarettes and a smoking apron was ordered for R6 to ensure her safety while smoking. DON stated her	F 689		

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F 689	Continued From page 12 expectation was that R6 was safe while smoking. A facility policy titled Smoking Policy-Residents revised 8/22, identified smoking was only permitted in designated resident smoking areas. Identified metal containers, with self-closing cover devices, are available in smoking areas. Identified an assessment to determine the ability to smoke was done for any resident who desired to smoke.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		1/20/25

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F 880	Continued From page 13 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 14 Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 4 residents (R34) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to implement hand hygiene for 3 of 3 residents (R3, R4, R5) observed during medication administration. Findings include: PPE Review of CDC guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R34's quarterly Minimum Data Set (MDS) dated 11/19/24, identified R34 had moderate cognitive impairment and diagnoses which included hypertension (elevated blood pressure), anxiety, and depression. Identified R34 required extensive assist with activities of daily living (ADL's) which included toileting, transfer, and dressing	F 880	Tag: F880 Corrective action to resident found to be affected: EBP sign placed on (R34) door and PPE equipment placed next to room. Verbal education provided to NA-B on enhanced barrier precautions on 12/18/24. Hand hygiene was performed by (LPN D) immediately. Verbal education completed with LPN D on handwashing 12/17/24. How the facility identified other residents' potential to be affected: Audit completed for all residents that received medication and treatment from LPN D. No signs or symptoms of infection. An audit was completed of all residents to ensure anyone who meets criteria for precautions had the appropriate signage and PPE in place. Measures put in place to ensure it will not recur: Education to team members on the handwashing policy. Education to team members on Enhanced Barrier precautions policy. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits, it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Nurses/RN Managers/Director of Nursing/designee	

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F 880	Continued From page 15 R34's care plan revised 12/9/24, indicated R34 had a catheter related to urinary retention. Care plan directed staff to monitor for any urinary tract infection (UTI) symptoms and report to medical doctor (MD). During an observation on 12/16/24 at 2:34 p.m., there was no PPE located near R34's room for staff to wear while providing care for R34 (who was on EBP). Further, there was no sign to identify R34 was on EBP. During an observation on 12/16/24 at 5:19 p.m., nursing assistant (NA)-C and NA-D entered R34's room, sanitized hands and applied gloves. NA-C and NA-D rolled R34 to her side and checked her brief which was dry and proceeded to place a hoyer sheet under R34 while standing within an inch of R34. NA-C and NA-D hooked R34 up to the hoyer using the lift sheet and placed R34 into her wheelchair. NA-C and NA-D were standing within an inch of R34 during the hoyer lift transfer. The only PPE NA-C and NA-D were wearing was gloves. During a joint interview on 12/16/24 at 5:39 p.m., NA-C and NA-D verified they had only worn gloves when transferring R34 into her wheelchair. NA-C and NA-D stated they understood that gloves were the only PPE required to care for R34. During an observation on 12/18/24 at 9:05 a.m., there was a plastic container with three drawers which contained gowns, gloves, masks, sitting on the floor next to R34's doorway. Additionally there was a sign on R34's room door that said Enhanced Barrier Precautions; Everyone Must	F 880	Date of completion: 1/20/25	

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F 880	Continued From page 16 clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer gown, and gloves. During an observation on 12/18/24 at 9:05 a.m., NA-B entered R34's room wearing no PPE and removed a wash basin for from R43's closet, went to the bathroom, filled the basin with water and placed three washcloths into the basin. NA-B went back to R34's closet, brought out a pair of pants and brought them to R34's bedside. NA-B walked up to R34 who was lying in bed and told her she was going to assist her with getting washed up and dressed. NA-B sanitized hands and applied gloves. NA-B proceeded to take a washcloth and wipe R34's armpits, rinsed and dried R34's armpits. NA-B applied new gloves and took a clean washcloth from the basin and cleaned R34's perineal area from front to back then used another washcloth to rinse R34's perineal area. NA-B removed gloves and placed a clean brief on R34. NA-B the proceeded to place R34's pants on her and roll R34 to her right side and pulled up the pants. At no time during the observation did NA-B wear a gown. During an interview on 12/18/24 at 9:35 a.m., NA-B verified the only PPE she had used while caring for R34 was gloves. NA-B stated she had forgotten what EBP was however stated she probably should have been wearing a gown while	F 880		

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F 880	Continued From page 17 caring for R34. HAND HYGIENE During a continuous observation on 12/16/24 at 7:05 p.m., LPN-D applied gloves and used a lancet (a device to poke a finger in order to get blood) to obtain blood to test R5's blood sugar. A small drop of blood landed on LPN-D's gloved finger on her right hand. LPN-D removed gloves and applied clean gloves and administered eye drops to each of R5's eyes. LPN-D removed gloves and placed R5's glucometer in the cupboard in R5's room. LPN-D walked to the med cart, removed medication for R4 and administered oral medications to R4. LPN-D proceeded to the med cart, touched the computer screen to sign out R4's medications, pulled out the narcotic book and signed out a narcotic for R3. LPN -D removed the narcotic from the med cart after touching several other cartridges in the narcotic drawer. LPN-D administered the narcotic to R3. At no time during the above observation did LPN-D perform hand hygiene. During an interview on 12/16/24 at 7:40 LPN-D verified she had not performed hand hygiene during the above observation. LPN-D stated she should have performed hand hygiene after removing the soiled gloves and before passing medications to each resident. During an interview on 12/18/24 at 9:39 a.m., infection preventionist (IP) confirmed R34 was on EBP. IP stated her expectations were PPE would have been readily available to care for any residents in EBP and staff would wear PPE when indicated. IP indicated her expectation was for	F 880		

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F 880	Continued From page 18	F 880		

staff to perform hand hygiene after removing gloves and before administering any medications to a resident.

During an interview on 12/18/24 at 10:10 a.m., director of nursing (DON) stated her expectation was that PPE would have been readily available to care for any residents in EBP and staff would have worn a gown and gloves while caring for R34. DON indicated her expectation was for staff to perform hand hygiene after removing gloves and before administering any medications to a resident.

A facility policy title Enhanced Barrier Precautions revised 8/22, identified EBP are used as an infection control and prevention intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. EBP employed targeted gown and glove use during high contact resident activities when contact precautions do not otherwise apply. Gowns and gloves are to be applied prior to performing the high contact activity. Examples of high contact activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.

A facility policy titled Handwashing/ Hand Hygiene revised 8/19, identified the facility considered hand hygiene the primary means to prevent the spread of infections. Identified an alcohol -based hand rub containing at lest 62% of alcohol or an anti-microbial soap should have been used before and after direct contact with a resident. Further identified hand hygiene was the final step

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F 880	Continued From page 19 after removing and disposing of personal protective equipment. . .	F 880		

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**12/17/2024**

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K 000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted on 12/17/2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Emmanuel Nursing Home was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

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

Electronically Signed | 01/02/2025

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.

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 addition to the east wing was constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111) construction. In 2004 a separate building (building 02) was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated from the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. In 2014 the Transitional Care was added and was determined to be of Type II (111) construction. The building is completely protected with an automatic fire sprinkler system and has a fire alarm system with corridor smoke detection in all common areas that is monitored. The 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations. The facility has a capacity of 62 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke	K 363		12/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**12/17/2024**

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K 363	Continued From page 3 and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3 and 19.3.6.3.5. This deficient finding	K 363	Corrective action taken: Part ordered and replaced. Door closes and latches when released from the magnetic hold-open device.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**12/17/2024**

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K 363	Continued From page 4 could have an isolated impact on the residents within the facility. Findings include: On 12/17/2024 between 9:45 AM and 12:45 PM, it was revealed by observation that the Basement Classroom Door did not close and latch when released from the magnetic hold-open device. An interview with the Executive Director and Building Maintenance Staff verified this deficient finding at the time of discovery.	K 363	Measures put in place to ensure deficiency does not reoccur: Door is on a quarterly check to inspect release and closure. Responsible Person(s): Environmental Services Director/Administrator/Designee responsible for compliance. Date of completion: 12/24/2024	