Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2023

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

RE: CCN: 245489
Cycle Start Date: October 4, 2023

Dear Administrator:

On October 4, 2023, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 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 January 4, 2024 (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 April 4, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

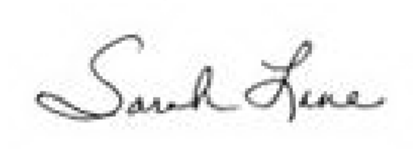
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
October 17, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: LZ0T11

Dear Administrator:

The above facility was surveyed on October 2, 2023 through October 4, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

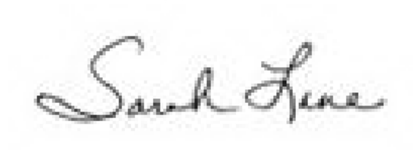
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 10/04/2023

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 10/2/23 to 10/4//23, 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 10/2/23, to 10/4/23, 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 deficiencies cited. H54895830C (MN00095008). H54896063C (MN00097192). The following complaints were reviewed with a deficiency cited at 689. H54895862C (MN00096624). H54896064C (MN00097246). 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	F 000		

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

Electronically Signed | 10/25/2023

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 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. 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were assessed for the ability to self administer medications (SAM) for 1 of 1 resident (R33) reviewed for medication administration. Findings include: R33's quarterly Minimum Data Set (MDS) dated 7/13/23, indicated R33 was cognitively intact. Identified R33 had diagnoses which included congestive heart failure (CHF), anxiety, depression and required extensive assistance from staff with activities of daily living (ADL's) which included transfers and toileting. R33's signed Physician Orders dated 9/15/23, revealed the following: - Tylenol 650 milligrams (mg) by mouth three times daily, used for pain management. - Coreg 25 mg tablet by mouth two times daily,	F 554	Tag: 554 Resident Self-Admin Meds-Clinically Appropriate Corrective action to resident found to be affected: It was determined by the Nurse Manager that R 33 is not eligible for self-administering medications. Education to nurse on self-administration process. How the facility identified other residents potential to be affected: Audit done on other residents to assure none were self-administering without proper assessment and care plan. Measures put in place to ensure it will not recur: Education to all nurses the process for a resident to self-administer medications. How the facility will monitor its	11/5/23

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F 554	Continued From page 2 used for high blood pressure. - Lasix 40 mg tablet by mouth one time daily, reduction of fluid in the body. - Multi-vitamin tablet by mouth one time daily, used for daily supplements. - Potassium Chloride extended release (ER) 20 milliequivalent (mEq) tablets by mouth two times daily, used for low potassium. - Sertraline Hydrochloride (Hcl) 75 mg tablet by mouth one time daily, used for anxiety. - Spironolactone 25 mg tablet by mouth one time daily, used for blood pressure. R33's care plan revised 7/28/23, indicated R33 had difficulty remembering what she did with her personal items and staff were to remind her where she placed things. Identified staff would administer medications as ordered by the physician, observe for side effects, and effectiveness. During an observations on 10/3/23 revealed the following: - At 9:23 a.m., licensed practical nurse (LPN)-C knocked on R33's door, LPN-C explained to R33 it was time to administer R33's medications. LPN-C retrieved medication cup from the medication cart, opened the medication safe in R33's room, placed seven morning medications into medication cup following R33's electronic medication administration record (eMAR). LPN-C placed the medication cup in R33's hand. R33 swallowed three medications from the cup with water and four medications remained in the medication cup. LPN-C asked R33 to continue to take her medications and R33 refused at that time. R33 requested she wait a few minutes before taking the remaining medications. LPN-C informed R33 she would return to ensure R33	F 554	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 Date of completion: 11/5/23	

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F 554	Continued From page 3 had taken the remaining four medications in the cup. LPN-C exited R33's room and continued to pass morning medications to other residents. -At 10:03 a.m., LPN-C had not returned to R33's room. R33 was sitting in her wheelchair in her room, medication cup not observed in R33's hand or room. R33's electronic health record (EHR) lacked a SAM assessment had been completed and an order for R33 to self administer medications. During an interview on 10/3/23 at 1:05 p.m., LPN-C indicated R33 usually took all of her medications with no issues. LPN-C stated R33's medication cup was in the garbage when she returned to R33's room and LPN-C assumed R33 took the remaining four medications however was not able to confirm it. During an interview on 10/4/23 at 2:12 p.m., the director of nursing (DON) confirmed the above findings. The DON indicated staff should not leave medications in R33's room as R33 did not have a SAM assessment completed. She stated she would expect staff to administer medications as ordered and remove them from her room when R33 refused to take them. A policy on self administration of medications was requested however was not provided.	F 554		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		11/5/23

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F 656	Continued From page 4 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656		

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F 656	Continued From page 5 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive person-centered care plan which included interventions and a goal related to smoking safety for 1 of 1 residents (R47) reviewed for accidents. Findings include: R47's facility admission record dated 9/1/23, identified R47 was admitted on 9/1/23, with diagnosis which included acquired absence of right ankle and foot, diabetes mellitus (DM), and hypertension (elevated blood pressure). Indicated R47 was a smoker and a smoking assessment had been completed. R47's admission Minimum Data Set (MDS) dated 9/7/23, indicated R47 had intact cognition and required limited assistance from staff with activities of daily living (ADL's) which included transfers and toileting. R47's care plan initiated 9/7/23, lacked documentation of a focus, goals or interventions of R47's smoking plan. During an interview on 10/2/23 at 1:40 p.m., R47 stated he was a current smoker in the facility and had been since admission. During an interview on 10/3/23 at 2:29 p.m., nursing assistant (NA)-B stated R47 was a smoker and she had been informed R47 was	F 656	Tag: 656 Develop/Implement Comprehensive Care plan Corrective action to resident found to be affected: R 47's Care plan was updated. How the facility identified other residents potential to be affected: Audit done on other residents to assure all care plans were up to date. Measures put in place to ensure it will not recur: Education to staff on updating care plan. 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: RN Managers/Supervisors/Director of Nursing/ Social Services or designee Date of completion: 11/5/23	

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F 656	Continued From page 6 expected to go to a nurse to obtain a cigarette when he wanted to smoke. NA-B indicated she was not aware of any further interventions staff were expected to implement when R47 went to smoke. NA-B stated R47's care plan lacked interventions regarding his smoking. During an interview on 10/3/23 at 2:33 p.m., NA-A indicated R47 was a smoker and he was to expected to go to a nurse when he wanted to smoke. NA-A stated she was not aware of any further interventions staff were expected to implement when R47 went to smoke. NA-A confirmed R47's care plan lacked interventions regarding smoking. During an interview on 10/3/23 at 2:40 p.m., registered nurse (RN)-A verified R47 was a smoker and stated R47 was expected to go to a nurse to obtain a cigarette and lighter when he wanted to smoke. RN-A stated R47 was to go downstairs and outside to smoke. RN-A stated she was not aware of any further interventions staff were to implement when R47 went to smoke. RN-A confirmed R47's care plan lacked interventions regarding smoking. During an interview on 10/3/23 at 2:53 p.m., nurse manager (NM)-B verified R47 was a smoker. NM-B confirmed R47's care plan lacked documentation R47 was a smoker and interventions related to smoking. During an interview on 10/4/23 at 1:03 p.m., director of nursing (DON) verified R47 was a smoker. DON confirmed R 47's care plan lacked documentation R47 was a smoker and interventions related to smoking. DON stated her expectations were R47's care plan would have	F 656		

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F 656	Continued From page 7 included a focus, goal and interventions related to R47's smoking practices. Review of a facility policy titled Care Plans, Comprehensive Person-Centered revised 3/2022, indicated the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, would develop and implement a comprehensive, person-centered care plan for each resident. Indicated care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and monitor for 1 of 1 resident (R33) who was reviewed for non-pressure related skin issues related to a bruise obtained from the patient assisted lift (PAL) for transfers. Findings include:	F 684	Tag: 684 Quality of care Corrective action to resident found to be affected: Bruised area to R33 was measured and being monitored daily. How the facility identified other residents' potential to be affected: Audit done on other residents to assure bruises are	11/5/23

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	245489	A. BUILDING _____ B. WING _____	C 10/04/2023

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F 684	Continued From page 8 R33's quarterly Minimum Data Set (MDS) dated 7/13/23, indicated R33 was cognitively intact and had moderate difficulty hearing. Identified R33 had diagnoses which included congestive heart failure (CHF), anxiety, depression and required extensive assistance from staff with activities of daily living (ADL's) which included bed mobility, toileting and was totally dependent with transfers. Further, the MDS identified R33 used a wheelchair to move around the unit. R33's annual Care Area Assessment (CAA) dated 2/6/23, identified R33 had diagnoses which included lower extremity edema, atrial fibrillation (A-Fib), hypertension, chronic kidney disease (CKD), and degenerative joint disease (DJD) of shoulder. Indicated R33 had balance problems during transfers. R33's current care plan, revised 10/3/23, revealed R33 required extensive assistance of one staff and a PAL for transfers. The care plan identified R33 required the use of sheepskin under right arm for protection when transferring with the PAL. Indicated daily skin inspections would be completed and documented. Review of R33's Progress Notes dated 8/3/23 to 10/4/23, revealed the following: - On 9/7/23, at 10:26 p.m. R33 was unable to pivot onto the toilet, staff member had to lower R33 to the floor. - On 9/15/23, at 11:12 a.m. R33 had been experiencing weakness with transfers and staff had been utilizing PAL as needed (PRN). - On 9/20/23, at 8:30 p.m. R33 had been complaining of pain in her right armpit, observed a large, 2.5" x 3.5" bruise on R33's right outside of breast. 2.5" x 2.5" area on lateral right breast	F 684	being monitored appropriately. Measures put in place to ensure it will not recur: Education to staff on the steps to take when a bruise is found and monitoring to be done. 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: RN Managers/Supervisors/Director of Nursing/Administrator or designee Date of completion: 11/5/23	

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F 684	Continued From page 9 had small dark purple spots, remaining 1" of bruise extending medially was light blue. Suspected R33 obtained bruise from the PAL lift as R33 had been relying on her arms to hold her up rather than using mostly leg strength. In addition, R33 indicated the bruise was from the use of the PAL. - On 9/21/23, at 8:21 p.m. staff reported the bruise to the right breast had grown larger from yesterday. R33's international normalized ratio (INR), (a blood test used to tell how long it takes for someone's blood to clot when taking blood thinners) was elevated a few days ago which would cause her to bleed easily due to being thin. A marker was used to outline the bruise to monitor for changes. Staff were to use sheep skin during transfer with the PAL. - On 9/22/23, at 12:54 p.m., R33 was seen by the nurse practitioner (NP) to review weakness and bruising obtained from PAL. Significant dark purple bruising observed to right breast, chest, and side. R33 indicated increased discomfort to right upper extremity. Order obtained for pain management. Coumadin (a blood thinner medication) discontinued due to evaluated INR levels. Review of R33's electronic health record (EHR) lacked documentation the facility had continued to monitor, reassess, and report any changes to the nurse regarding R33's bruising. During an observation and interview on 10/2/23, at 1:10 p.m. R33 lifted her shirt while sitting in her room in her wheelchair revealing a large bruise which covered her entire right breast that extended towards R33's back and around the right side under her armpit. The bruising to the right breast was yellow/green and the bruising to	F 684		

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F 684	Continued From page 10 the side towards the back was deep purple. R33 indicated she felt some pulling and scratching during the PAL transfer. After the transfer was complete, R33 stated she felt some pain and discomfort. R33 said the bruise appeared a few days later. Review of R33's electronic health record (EHR) lacked documentation the facility had continued to monitor, document, and report any changes to the nurse regarding R33's bruising. During an observation on 10/4/23 at 7:16 a.m., nursing assistant (NA)-C assisted R33 from her bed to the bathroom via the PAL. NA-C placed the PAL support belt around R33 who was seated on the edge of the bed, placed sheepskin on support belt under R33's right arm and placed the hook straps onto the PAL. NA-C instructed R33 to hold onto the handles of the PAL and to stand up with the PAL. PAL strap rested underneath R33's armpits along both sides and secured moveable buckle strap was placed around waist. R33 was informed she was going to be lifted to a standing position and brought to the bathroom. R33 could not support herself on the PAL and did not use her legs to assist with standing. R33 was hanging by the support belt of the PAL to transfer to the toilet. After ADL's completed, PAL belt was placed around resident, sheepskin placed on support belt under right arm and hook straps placed onto PAL. NA-C instructed R33 to hold onto the handles and use her legs to stand up. Again, R33 did not use her legs to assist with standing and was not able to support herself while using the PAL. As a result, R33 was hanging by the PAL support belt during the transfer to her wheelchair. .	F 684		

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F 684	Continued From page 11 During an interview on 10/2/23 at 2:12 p.m.,resident representative (RR)-A indicated a couple weeks ago R33 had large bruise on her right side and right breast. RR-A revealed R33 was taking coumadin, a medication to thin the blood, and R33 had bruised easily. RR-A further revealed, the NP took resident off coumadin. During an interview on 10/3/23 at 3:32 p.m. , NA-D explained nursing care notes described the level of care required for residents including transfer methods and were used by the NA's. NA-D stated R33 required extensive assistance for ADL's which included bed mobility, toileting, and transfers. NA-D stated she was not aware R33 had a large bruise on her right breast. During an interview on 10/4/23 at 12:31 p.m. ,nurse manager (NM)-C confirmed the above findings and indicated she was aware of the bruise. NM-C indicated R33 saw her primary provider about the brusing. NM-C stated nursing staff were expected to monitor, document, and inform the nurse if the bruise worsened. During an interview on 10/4/23 at 1:45 p.m., the director of nursing (DON) confirmed the above findings and indicated R33's bruise was not monitored as it should have been by nursing staff. DON stated her expectations were for nursing staff to monitor and measure the bruise consistently until the bruise had healed. DON indicated she expected any changes in condition of the bruise would need be brought to the nursing managers' attention for further follow-up. Requested a policy on monitoring bruises however one was not provided. .	F 684		

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F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure proper treatment was provided to maintain hearing for 1 of 1 residents (R33) reviewed for hearing. Findings include: R33's quarterly Minimum Data Set (MDS) dated 7/13/23, indicated R33 was cognitively intact and had moderate difficulty hearing. R33's Care Area Assessment (CAA) dated 2/6/23, indicated R33 had the potential for communication deficits related to her hearing impairment. Identified R33 had poor hearing in both ears and R33 could hear better in right ear. Indicated R33 had a history of cerumen build up. R33's care plan dated 7/27/23, indicated R33 would be referred to audiology for a hearing consult as ordered and directed by resident and/or her representative.	F 685	Tag: 685 Treatment/Devices to Maintain Hearing/Vision Corrective action to resident found to be affected: Offered R33 hearing appointment along with transportation if needed. R33 declined. How the facility identified other residents potential to be affected: All residents were offered audiology if not done so recently. Measures put in place to ensure it will not recur: Education provided to staff to offer audiology appointments during care conferences and as needed. 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	11/5/23

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F 685	Continued From page 13 R33's electronic health record (EHR) lacked evidence R33 was offered an audiology appointment. During an interview on 10/2/23 at 2:25 p.m., R33's resident representative (RR)-A stated R33 was hard of hearing and was not aware if resident had ever had a hearing exam. RR-A indicated she suggested to staff R33 should be fitted for hearing aids to assist with R33's hearing and had not heard back if an appointment had been scheduled. During an interview on 10/4/23 at 1:40 p.m., nurse manager (NM)-C confirmed the above findings and indicated R33 had not been offered a hearing exam since her care conference that was held on 4/23. NM-C indicated staff were expected to offer hearing exams during care conferences. During an interview on 10/4/23 at 1:45 PM, the director of nursing (DON) confirmed the above findings and stated her expectation was nursing managers would follow the policy regarding hearing exams. DON indicated she expected nursing managers to offer residents hearing exams during care conferences and to document the response in the EHR. A policy on hearing exams was requested however was not provided.	F 685	be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors/Director of Nursing/Social Services or designee Date of completion: 11/5/23	
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 -	F 689		11/5/23

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F 689	Continued From page 14 §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 ensure safe smoking interventions for 1 of 1 resident (R47) reviewed for smoking. In addition, the facility failed to ensure safe transfers with a patient assist lift (PAL) for 1 of 4 residents (R33) reviewed for accidents. Findings include: R47 R47's admission Minimum Data Set (MDS) dated 9/7/23, indicated R47 had diagnosis which included amputation, hypertension (elevated blood pressure), and diabetes mellitus (DM). Identified R47 had intact cognition and required limited assistance from staff with activities of daily living (ADL's) which included transfers and toileting. R47's admission Care Area Assessment (CAA) identified R47 identified interventions were in place to address R47's safety needs. R47's care plan initiated 9/7/23, lacked a focus, goal, and interventions for R47's smoking practices R47's progress notes dated 9/2/23 at 6:17 p.m., indicated a smoking assessment had been	F 689	Tag: 689 Free of Accident Hazards/Supervision/Devices Corrective action to resident found to be affected: Education provided to R47 on smoking area and where to discard his cigarette butts and voiced understanding. R33 changed from PAL to Hoyer lift. How the facility identified other residents potential to be affected: Audit done on other residents for current smokers. At the time of audit, no other smokers were identified. All residents were audited for safe and appropriate transfer methods. Measures put in place to ensure it will not recur: Education to staff on smoking area and interventions if residents are smoking in unauthorized area or unsafe. Education on the process if we identify unsafe transfers. 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.	

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F 689	Continued From page 15 completed. R47's smoking assessment dated 9/2/23, indicated R47 was safe to light the cigarette, wheel self out to smoke and back into the building again. The assessment lacked any assessment of R47's ability to safely extinguish or dispose the cigarette. During an interview on 10/2/23 at 1:40 p.m., R47 stated sometimes he went out into the parking lot to smoke and some times he would be redirected by staff to go downstairs and outside to smoke in the designated smoking area. During an observation on 10/2/23 at 3:15 p.m., R47 received a cigarette and lighter from registered nurse (RN)-A. R47 proceeded to wheel self outside into the parking lot about 100 ft from the building and lit the cigarette. R47 proceeded to sit in his wheelchair and smoke the cigarette. R47 flipped the cherry onto the ground, stomped on it with the sandal he was wearing on his left foot. R47 picked the cigarette butt off the ground, wheeled himself to the trash can which was located approximately 50 ft. from the building and disposed of the cigarette butt into the trash can. During an observation on 10/3/23 at 9:13 a.m., R47 received a cigarette from RN-A. R47 proceeded to wheel self outside into the parking lot about 100 ft. away from the building and lit his cigarette with a lighter he pulled from his pocket. R47 proceeded to sit in his wheelchair and smoke the cigarette. R47 flipped the cherry onto the ground and stomped on it with the sandal he was wearing on his left foot. R47 then picked the cigarette butt off the ground and placed it into his pocket and proceeded to wheel himself back to	F 689	Responsible Persons: RN Managers/Supervisors/Director of Nursing/Social Services/Administrator or designee Date of completion: 11/5/23	

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F 689	Continued From page 16 his room. During an interview on 10/3/23 at 1:31 p.m., R47 stated he always stomped on the cherry of the cigarette to extinguish the cigarette. R47 stated he then usually placed the cigarette butt in the trash can in the parking lot. R47 indicated he was not sure where the cigarette butt ended up yesterday that he had placed in his pocket. During an interview on 10/3/23 at 2:29 p.m., nursing assistant (NA)-A stated R47 was a smoker and was expected to go to a nurse when he wanted to smoke. NA-A indicated she was not sure of the process R47 used to extinguish or dispose of the cigarette after he smoked. During an interview on 10/3/23 at 2:40 p.m., RN-A verified R47 was a smoker and stated R47 was expected to go to a nurse to obtain a cigarette and lighter when he wanted to smoke. RN-A stated R47 was to go downstairs and outside to the designated smoking area however added he had been seen in the parking lot smoking. RN-A indicated she was not aware of the process R47 used to extinguish or dispose of the cigarette after he smoked. During an interview on 10/3/23 at 2:53 p.m., nurse manager (NM)-B verified R47 was a smoker and stated R47 was expected to go to a nurse to obtain a cigarette and lighter when he wanted to smoke. NM-B stated R47 was supposed to go downstairs and outside to the designated smoking area to smoke however stated he had been seen in the parking lot smoking. NM-B stated R47 was supposed to extinguish the cigarette on the ground and throw the butt in the receptacle. NM-B indicated she	F 689		

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F 689	Continued From page 17 had not seen R47 extinguish or dispose of any cigarette butts and was not aware of the process he used to extinguish or dispose of the cigarette butt. R33 R33's quarterly MDS dated 7/13/23, indicated R33 was cognitively intact and had diagnoses which included congestive heart failure (CHF), anxiety and depression. Identified R33 required extensive assistance from staff with activities of daily living (ADL's) which included bed mobility, toileting and was totally dependent with transfers. R33's annual CAA dated 2/6/23, identified R33 had diagnoses which included lower extremity edema, atrial fibrillation (A-Fib), hypertension,	F 689		

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F 689	Continued From page 18 chronic kidney disease (CKD), and degenerative joint disease (DJD) of shoulder. Indicated R33 had balance problems during transfers. R33's current care plan, revised 10/3/23, revealed R33 required extensive assistance of one staff and the use of a PAL for transfers. Identified R33 required the use of sheepskin under right arm for protection when transferring with the PAL. Indicated R33 was to receive evaluations from physical therapy (PT)/occupational therapy (OT) per physicians orders. Nursing staff were expected to follow PT/OT recommendations. Review of R33's physicians orders signed 9/15/23, identified R33 had orders to work with PT to evaluate and treat weakness with transfers. Review of R33's progress notes dated 8/3/23 to 10/4/23, revealed the following: - On 9/7/23, at 10:26 p.m. R33 was unable to pivot onto the toilet, staff member had to lower R33 to the ground. - On 9/15/23, at 11:12 a.m. R33 had been experiencing weakness with transfers and staff had been utilizing a PAL as needed (PRN). On 9/15/23, at 4:05 p.m. R33 was seen by nurse practitioner (NP) during routine visit. R33 had been displaying confusion and experiencing weakness. NP placed orders for labs. - On 9/20/23, at 8:30 p.m. R33 had been using the PAL for all transfers and had been relying on her arms to hold her up rather than using mostly leg strength. - On 9/21/23, at 8:21 a.m. R33 received orders for PT/OT to evaluate transfers and wheelchair placement. During an observation and interview on 10/2/23 at	F 689		

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F 689	Continued From page 19 1:10 p.m., R33 indicated she was having pain on her right side. R33 lifted her shirt and revealed a large bruise which covered the entire right breast and extended towards the back and around her right side. R33 stated she felt some pulling and scratching during a recent PAL transfer. During an observation on 10/4/23 at 7:16 a.m., nursing assistant (NA)-C assisted R33 from bed to the bathroom via the PAL. NA-C placed the PAL support belt around R33 who was seated on the edge of the bed, placed sheepskin on support belt under R33's right arm and placed the hook straps onto the PAL. NA-C instructed R33 to hold onto the handles of the PAL and to stand up with the PAL. PAL strap was rested underneath R33's armpits along both sides and secured moveable buckle strap was placed around waist. R33 was informed she was going to be lifted to a standing position and brought to the bathroom. R33 could not support herself on the PAL and did not use her legs to assist with standing. R33 was hanging by the support belt of the PAL to transfer to the toilet. After ADL's completed, PAL belt was placed around resident, sheepskin placed on support belt under right arm and hook straps placed onto PAL. R33 instructed to hold onto the handles and use her legs to stand up. Again, R33 did not use her legs to assist with standing and was not able to support herself while using the PAL. Again, R33 was hanging by the PAL support belt during the transfer PAL and staff continued to lift R33 to a standing position to transfer from the toilet to her wheelchair. R33 was lowered into her wheelchair. During an interview on 10/4/23 at 11:46 a.m., NA-E indicated R33 had become very weak lately and required a PAL lift for transfers. NA-E	F 689		

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F 689	Continued From page 20 confirmed the PAL was not appropriate for transfers with R33. NA-E indicated R33 hung in the PAL support belt and did not attempt to stand and revealed R33 did not want to use an alternative mechanical lift for transfers. During an interview on 10/2/23 at 2:12 p.m., resident representative (RR)-A indicated R33 was currently being transferred with the PAL and had been for the past couple weeks. RR-A stated R33 had to be lowered to the floor during a bathroom transfer one day which resulted in her requiring the use of the PAL for transfers. During an interview on 10/3/23 at 3:32 p.m., NA-D explained nursing care notes were used by NA's and described the required care for residents which included transfer methods. NA-D stated the nursing care notes revealed R33 required a pivot transfer with the assist of one staff however NA-D identified R33 was actually being transferred with a PAL. NA-D indicated R33 required extensive assistance for ADL's which included bed mobility, toileting, and transfers. During an interview on 10/3/23 on 3:54 p.m., registered nurse (RN)-B indicated R33 required extensive assistance with ADL's and transfers. RN-B revealed NA's used nursing care notes to care for residents on the unit. RN-B stated R33 was to be transferred with the assist of one and pivot turns. During an interview on 10/3/23 at 4:00 p.m., nursing manager (NM)-C identified R33 required extensive assistance from staff with ADL's and transfers. NM-C indicated R33 had a recent decline related to weakness and R33 required to be transferred with the PAL. NM-C stated R33	F 689		

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F 689	Continued From page 21 had worked with therapy for guidance with transfers in the past however R33 no longer worked with therapy. NM-C confirmed staff reported R33 was very weak and hanging in the PAL support belt during transfers. NM-C staled R33 had orders for PT/OT recently however R33 refused to work with PT/OT due to pain on R33's right side where the bruising was noted. During an interview on 10/4/23 at 12:02 p.m., physical therapy assistant (PTA)-A contacted supervisor who indicated R33 refused the PT evaluation for rehab and PAL assistance training on three separate occasions. PTA-A confirmed R33 was hanging in the PAL support belt during transfers and verified the PAL was not appropriate for R33's transfers. During a follow-up interview on 10/4/23 at 12:31 p.m., NM-C confirmed the above findings and indicated R33 had refused PT due to R33 having pain on the right side. NM-C stated R33 had refused other methods for transferring and staff continued to use the PAL. NM-C indicated the PAL was not an appropriate method to transfer R33 as R33 was not able to support herself safely with her legs. NM-C stated as a result, R33 would end up hanging in the PAL support belt and NM-C confirmed using the PAL for R33's transfers was not a safe transfer method. During an interview on 10/4/23 at 1:03 p.m., director of nursing (DON) verified R47 was a smoker. DON confirmed R47 had been seen smoking in the parking lot however was not aware how he extinguished or disposed of the cigarette butts. DON stated R47 was independent with going out to smoke so no staff usually accompanied him while he smoked. DON stated	F 689		

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F 689	Continued From page 22 her expectation was R47 would have gone downstairs and outside to the designated smoking area to smoke and extinguish his cigarette in the receptacle then place the cigarette butt in the receptacle. During an interview on 10/4/23 at 1:45 p.m., the director of nursing (DON) confirmed the above findings and indicated R33 was not being transferred safely. DON stated her expectations were for staff to transfer residents safely and when transfers became more difficult, staff would inform the floor nurse or nurse manager. DON indicated once the floor nurse or nurse manager was notified, the resident would be evaluated for a safer transfer method. Review of a facility policy titled Smoking Policy revised 8/22, indicated smoking was only permitted in designated resident smoking areas. Identified ashtrays were only emptied into designated receptacles. Review of the facility policy titled, Transferring Residents, revised 5/2023, revealed the following after discussions with nursing personnel, the nurse in charge would make the decision of which residents would to be lifted/transferred with the assistance of more than one person and/or use of a mechanical assistive device (i.e. PAL Lift). Any resident who could not transfer independently or pivot without assistance of one would have their transfer accomplished with two or more persons and/or a mechanical device. Any resident unable to bear weight would be transferred with a mechanical device.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		11/5/23

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F 725	Continued From page 23 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide routine assistance with activities of daily living (ADL's) for 1 of 1 resident (R11) who was dependent on staff for ADL's. In addition, one resident (R31) and 3 of 5 of the resident council members (R11, R17 and R1) voiced concerns with an inadequate number of staff to routinely meet their needs in a timely	F 725	Tag: F725 Sufficient Nursing Staff Corrective action to resident found to be affected: R11 call light was answered and discussion with R11 on how we can better accommodate his needs/routine to reduce call light time. How the facility identified other residents'	

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F 725	Continued From page 24 manner. Findings include: R11 R11's quarterly Minimum Data Set (MDS) dated 8/1/23, identified R11 had diagnoses which included Multiple Sclerosis (MS) and depression. Identified R11 was cognitively intact and was dependent upon staff with ADL's of dressing, transferring, and toileting. During an interview on 10/2/23, at 12:38 p.m. R11 indicated call lights were not answered timely and he had to wait an hour or more at times for his call light to be answered. During observations on 10/2/23, revealed the following: - At 12:46 p.m., R11 turned his call light on, stated he had a wet brief and stated he required assistance with changing his brief. - At 1:03 p.m., R11 wheeled out to the hallway and stated he continued to wait for assistance. Call light remained on and unanswered. A staff member walked past R11 and stated she would get assistance for him. - At 1:08 p.m., R11 continued to sit in the hallway and stated he had a bowel movement and continued to wait for assistance to be changed. Call light remained on and unanswered. - At 1:13 p.m., nursing assistant (NA)-F walked past R11 however did not address R11's current call light on. NA-F walked past R11 again and stated she was looking for someone to assist. She continued to say that she needed to find her partners however did not know where they were.	F 725	potential to be affected: Audit done on other residents call lights response time. Measures put in place to ensure it will not recur: Education to all staff on answering call lights and the process to take if unable to answer timely. Policy reviewed and updated. 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: RN Managers/Supervisors/Director of Nursing/Social Services/Administrator or designee. Date of completion: 11/5/23	

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F 725	Continued From page 25 NA-F went on to answer another resident's call light and carry a food tray out of the room down the hallway. R11's call light remained on and unanswered. - At 1:19 p.m., NA-F wheeled R11 into his room to assist him and turned the call light off. R11's call light was on for a total of 33 minutes prior to staff assisting him. During observations on 10/3/23, revealed the following: - At 9:20 a.m. R11 turned his call light on for assistance. R11 was sitting in his room in his wheelchair watching television, R11 had a blue ball between his legs per physical therapy (PT) orders . - At 9:45 a.m. R11 wheeled himself in his wheelchair into the hallway and was sitting in the hallway with the blue ball between legs. Call light remained on and unanswered. Licensed practical nurse (LPN)-C walked past R11 two times however did not approach or offer assistance to R11. - At 9:49 a.m. R11's call light was turned off and NA pushed resident into room to assist him. R11's call light was on for a total of 29 minutes prior to staff assisting him. R31 R31's entry tracking record MDS dated 9/20/23, identified R31 had been admitted to the facility on 9/20/23. During an interview on 10/2/23, on 12:48 p.m. R31 indicated it took on average a half hour for	F 725		

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F 725	Continued From page 26 his call light to be answered. R31 further indicated due to the long wait time R31 had soiled his brief. R31 revealed all shifts had long call light wait periods. During a resident council meeting held on 10/3/23 at 1:43 p.m., three residents expressed concerns for sufficient staffing. R1 stated sufficient staffing had been a problem for a long time as evidenced by long call light wait times. She indicated she informed new residents they could expect to wait 20-25 minutes for their call light to be answered. R1 stated on the weekends, she has waited over an hour at times for her call light to be answered at times. She indicated she has become soiled in her incontinent brief when she has waited for staff to answer her call light. In addition, June stated she preferred to get up early in the morning and could not get up early on the weekends due to staffing shortages. R11 and R17 voiced agreement with long call light wait times. During an interview on 10/2/23 on 12:48 p.m., R31 indicated it frequently took a half hour or longer to have his call light answered. R31 stated he had soiled his brief at times due to the long call light wait times. R31 indicated he had to wait a long time for his call light to be answered on all three shifts. During an interview on 10/4/23 at 11:55 a.m., NA-E indicated the long-term care (LTC) unit had often times worked short staffed and only had two NA's on the floor. NA-E confirmed NA's would get behind with their work tasks and it became harder to complete all the required work. NA-E stated the LTC unit should have been staffed with a minimum of three NA's and two nurses. NA-E indicated resident call lights would remain	F 725		

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F 725	Continued From page 27 unanswered for a long period of time due to the fact they were usually running behind. During an interview on 10/4/23 at 12:51 p.m., nurse manager (NM)-C confirmed the above findings and indicated the LTC unit was expected to be scheduled with four to five staff including nurses. NM-C indicated nursing working on the floor were required to provide assistance to residents, answer call lights, and assist the NA's with getting residents up/down for the the day. NM-C stated her expectations were staff to have resident call lights answered within 10 to 15 minutes. During an interview on 10/4/23 at 2:21 p.m., the director of nursing (DON) confirmed the above findings and indicated residents had long call light wait times. DON stated her expectations were that all call lights were answered timely with a goal of 10 minutes. She indicated she would expect staff to ask for assistance from nurse managers when they were not able to answer call lights in a timely manner. Review of facility Daily Staffing Forms from 9/3/23 to 10/7/23, indicated each floor had the full complement of staff scheduled per facility staffing guidelines however did not identify staffing changes that occurred when staff were absent, etc. Review of facility policy titled Answering the Call Light, revised September 2022, stated the purpose of the call light was to ensure timely response to the resident's requests and needs. Answer the residents call system immediately. If assistance is needed when you enter the room, summon help by using the call signal. When	F 725		

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F 725	Continued From page 28 answering a visual request for assistance, address the resident by name. Document and significant requests or complaints my by the resident and how the request or complaint was addressed. Review of facility policy titled, Staffing, Sufficient and Competent Nursing, revised August 2022, Licensed nurses and certified nursing assistants were available 24 hours a day, seven (7) days a week to provide competent resident care services including: assuring residents safety and responding to resident needs. Staffing number and the skill requirements of direct care staff were determined by the needs of the residents based on each resident's plan of care, the resident assessment and the facility assessment.	F 725		
F 880 SS=E	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	F 880		11/5/23

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F 880	Continued From page 29 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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: (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.	F 880		

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F 880	Continued From page 30 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: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 1 of 2 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 10/3/23 at 9:50 a.m., laundry aide (LA)-A pushed an uncovered cart that contained personal laundry which consisted of pants and shirts on hangers. Proceeded down the hallway, removed laundry from the uncovered cart and placed in R47's closet. LA-A walked back into the hallway, removed laundry from the uncovered cart and placed in R10's closet. LA-A then pushed the uncovered cart into the elevator and back to the laundry room. During an observation on 10/3/23 at 2:36 p.m., nursing assistant (NA)-B pushed an uncovered cart which contained clean wash cloths, towels,	F 880	Tag: F880 Infection Prevention & Control Corrective action to resident found to be affected: All linen carts were covered How the facility identified other residents' potential to be affected: Audit conducted for all linen carts to assure they were covered. Measures put in place to ensure it will not recur: Education to staff that clean carts need to be covered when not in use. 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: RN Managers/Supervisors/Director of Nursing/Social Services/Administrator or designee Date of completion: 11/5/23	

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F 880	Continued From page 31 and gowns down the hallway. NA-B removed two towels, wash cloths, and a gown from the uncovered cart and placed them on a counter in R202's room. NA-B proceeded back into the hallway and removed two towels, wash cloths and a gown off the uncovered cart and placed them on a counter in R203's room. During an interview on 10/3/23 at 2:51 p.m., NA-B confirmed the linen she delivered had not been covered. NA-B stated her usual practice was to place the linen on an uncovered cart and she was unaware that the linen cart should have been covered. During an interview on 10/4/23 at 7:39 a.m., LA-A confirmed the personal laundry she delivered had not been covered. LA-A stated her usual practice was to ensure the laundry cart was covered however at times left the cart uncovered. During an interview on 10/4/23 at 7:44 a.m., laundry manager (LM) stated she had seen laundry being delivered uncovered. LM she was aware laundry needed to be covered while being delivered and stated her expectation was laundry would have always been covered while being delivered. During an interview on 10/4/23 at 1:03 p.m., director of nursing (DON) stated she was aware laundry needed to be covered while being delivered. DON further stated her expectation was laundry would have been covered while being delivered. Review of a policy titled Laundry and Bedding. Soiled revised 9/22, indicated laundry should be handled, transported and processed according to	F 880		

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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
F 880	Continued From page 32 best practices for infection prevention and control. Identified clean linen was protected from dust and soiling during transport and storage to ensure cleanliness.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		11/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
F 883	Continued From page 33 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R1, R11, R18 and R31) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the Current CDC recommendations 3/15/2023, revealed the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 at age 65 and older, based on shared clinical decision-making, should receive one dose of PCV20 at least five years after the last pneumococcal vaccine dose.	F 883	Tag: F883 Influenza and Pneumococcal Immunizations Corrective action to resident found to be affected: Pneumococcal vaccine offered and/or administered to all residents. How the facility identified other residents' potential to be affected: Audit done on all residents and offered and/or administered pneumococcal vaccine per CDC guidelines. Measures put in place to ensure it will not recur: Education to nurse managers on updated pneumococcal vaccine	

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 883	Continued From page 34 Indicated individuals who received PCV13 at any age and PPSV23 before the age of 65 should receive one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R1's facesheet, identified R1, age 82 was admitted to the facility on 2/1/2022. Review of R1's Minnesota Immunization Information Connection (MIIC) undated, identified R1 had received PPSV23 on 1/1/2007, 1/6/2010, 11/23/2015 and received PCV13 on 10/18/2017. R1's medical record lacked documentation R1 had been offered the PCV20 vaccine. Review of R11's facesheet, identified R11, age 66 was admitted to the facility on 1/6/2020. Review of R11's MIIC undated, identified R11 had received the PPSV23 on 10/14/2014, and the Pneumo- PCV13 on 11/18/2016. R11's medical record lacked documentation R11 had been offered or received the PCV20 vaccine. Review of R18's facesheet, identified R18, age 79 was admitted to the facility on 8/31/2023. Review of R18's MIIC undated, identified R18 had received the PPSV23 on 2/2/2010 and 12/9/2011, and received the PCV13 on 5/5/2016. R18's medical record lacked documentation R18 had been offered or received the PCV20 vaccine. Review of R31's facesheet, identified R31, age 80 was admitted to the facility on 4/28/2023. Review of R31's MIIC undated, identified R31 had received the PPSV23 on 3/9/2008, and 10/28/2013, and received the PCV13 on 3/9/2008, and 10/26/2015. R31's medical record lacked documentation R31 had been offered or received the PCV20 vaccine.	F 883	recommendations. 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: RN Managers/Supervisors/Director of Nursing or designee Date of completion: 11/5/23	

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F 883	Continued From page 35 During an interview on 10/4/23 at 11:36 a.m., infection preventionist (IP) confirmed R1, R11, R18, and R31 had not been been offered or received the pneumococcal vaccinations as recommended by the CDC. IP stated the expectation was the facility would offer or administer all vaccinations per CDC recommendations. During an interview on 10/4/23 at 11:45 a.m., director of nursing (DON) stated they had been planning to offer and administer the new pneumococcal vaccines to all residents who had not yet received them. DON confirmed R1, R11, R18, and R31 had not been offered or received the pneumococcal vaccines. DON further stated her expectation would have been that all residents would have been offered and received all pneumococcal vaccines per Centers For Disease Control (CDC) recommendations. Facility policy titled Influenza, PPV, and COVID -19 Vaccination revised 2/2023, indicated residents were assessed to determine if the administration of the pneumococcal vaccine was appropriate based on CDC guidelines. Identified when not administered, documentation as to why the vaccine was not provided would have been in the medical record.	F 883		

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 _____	**10/03/2023**

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	INITIAL COMMENTS An annual Life Safety recertification survey was conducted on 10/03/2023, 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		10/26/2023

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.

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 _____	**10/03/2023**

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EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

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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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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**10/03/2023**

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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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 form 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 and 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 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K 291		11/5/23

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**10/03/2023**

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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K 291	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9.3.1.1, 7.9.2.1, and 7.9.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/03/2023 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that the emergency lighting inspection report that the facility provided did not list the locations of the emergency lighting, so the surveyor could not verify if all of the emergency lights were tested. An interview with the Administrator and the Maintenance Tech verified this deficient finding at the time of discovery.	K 291	Corrective action taken: All emergency light locations were added to a log. Measures put in place to ensure deficiency does not reoccur: Facility implemented a log which includes a list of locations of the emergency lighting which will be utilized during routine checks of the emergency lighting. Responsible Person(s): Environmental Services Director/Administrator/Designee Date of completion: 11/5/2023	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321		11/5/23

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K 321	Continued From page 4 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. These deficient findings could have an widespread impact on the residents within the facility. Findings include: On 10/03/2023 at 12:00 PM, it was revealed by observation that resident rooms 1-6, 101 and 108 did not have door closers and were being used as combustible storage rooms. An interview with the Administrator and Maintenance Tech verified these deficient findings at the time of discovery.	K 321	Corrective action taken: Rooms 1-6 were converted back to resident rooms. Hinges were changed on rooms 101 and 108. Measures put in place to ensure deficiency does not reoccur: All team members educated to only use designated storerooms for storage. Responsible Person(s): Environmental Services Director/Administrator/Designee Date of completion: 11/5/2023	
K 361 SS=D	Corridors - Areas Open to Corridor	K 361		11/5/23

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EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

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K 361	Continued From page 5 CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spaces open to the corridor per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/03/2023 at 10:00 AM, it was revealed by observation that the business center doors have been removed and is now open to the corridor and the space did not contain smoke detection. An interview with the Administrator and Maintenance Tech verified this deficient finding at the time of discovery.	K 361	Corrective action taken: Smoke detector added to business center. Measures put in place to ensure deficiency does not reoccur: Education to environmental services team members on NFPA 101 (2012 edition) Life Safety Code, section 19.3.6.1. Reponsible Person(s): Environmental Services Director/Administrator/Designee Date of completion: 11/5/2023	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 16, 2023

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

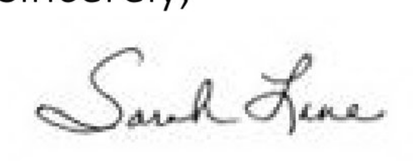
RE: CCN: 245489
Cycle Start Date: October 4, 2023

Dear Administrator:

On November 13, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 16, 2023

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

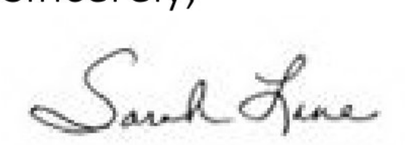
Re: Reinspection Results
Event ID: LZ0T12

Dear Administrator:

On November 13, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 4, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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