

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 15, 2021

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

RE: CCN: 245489

Cycle Start Date: January 4, 2021

Dear Administrator:

On January 4, 2021, 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.

Emmanuel Nursing Home January 15, 2021 Page 2

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" tag) i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343

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

Emmanuel Nursing Home January 15, 2021 Page 3

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 April 4, 2021 (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 July 4, 2021 (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.

Emmanuel Nursing Home January 15, 2021 Page 4

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 15, 2021

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

Re: Event ID: VT0811

Dear Administrator:

The above facility survey was completed on January 4, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Electronically

March 1, 2021

Danielle Olson Emmanuel Nursing Home 1415 Madison Avenue Detroit Lakes, MN 56501

Subject: Emmanuel Nursing Home – Administrative review 2567 modification

CMS Certification Number (CCN): # 245489

Event ID: VT0811

Dear Danielle:

This is notice of an administrative review of a citation cited at tag F600 issued pursuant to the survey Event ID VT0811, completed on January 4, 2021 as a part of MDH's Quality Assurance review. As a result of this review, it was determined the deficiency cited did not represent an immediate jeopardy situation, and confirmed you had already implemented corrective action to remove the deficient practice prior to our onsite survey.

Since we have determined this is not a valid example of a current deficient practice under this regulation, it will be removed from the Statement of Deficiencies.

A revised Statement of Deficiencies is attached.

Sincerely,

Kathleen Lucas, Unit Supervisor Licensing and Certification Program

Health Regulation Division Telephone: 320-223-7343

cc: Office of Ombudsman for Long-Term Care

Pam Malterud, Assistant Program Manager

Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED	
			7 5 0 . 1 5 1 0 .			:
		00013	B. WING		1	4/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EMMAN	UEL NURSING HOME		DISON AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
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	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited cted, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of I lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	visited the above pr	rS: vor of this Department's staff ovider for a complaint o correction order was issued.				
	substantiated:	laint was found to be licensing order issued.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 01/20/21

TITLE

Minnesota Department of Health

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	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far leading. The state statisted in the "Summ column and replace the correction order the findings which a statute after the states as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for he assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is hary Statement of Deficiencies" les the "To Comply" portion of r. This column also includes hare in violation of the state htement, "This Rule is not met collowing the surveyors findings Method of Correction and harection.				
	receipt of State lice the Minnesota Dep. Informational Bullet http://www.health.s obul.htm The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "cor text. You must then State licensure proc completion date, th corrected prior to e Minnesota Departm PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				

Minnesota Department of Health

STATE FORM 6899 VT0811 If continuation sheet 2 of 3

Minnesota Department of Health

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Minnesota Department of Health

STATE FORM 6899 VT0811 If continuation sheet 3 of 3

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 01/25/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
					(С
		245489	B. WING _		01/	04/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EMMAN	JEL NURSING HOME			1415 MADISON AVENUE DETROIT LAKES, MN 56501		
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F 000	INITIAL COMMENT	ΓS	F 00	00		
	at your facility to co investigation. Your compliance with 42 for Long Term Care The following comp substantiated:	facility was found not to be in CFR Part 483, Requirements				
F 600 SS=D	as your allegation of Department's accept enrolled in ePOC, year the bottom of the form. Your electron be used as verificated Upon receipt of an enrolled in ergulation on the state of your verification. Free from Abuse are possible of possible properties and the properties of the p	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 60	00		2/9/21
	§483.12 Freedom f Exploitation The resident has th neglect, misapprop and exploitation as includes but is not I corporal punishmer	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.				
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 01/20/2021
LICCUOI	lically Signed					U 1/2U/2U2 I

(X2) MULTIPLE CONSTRUCTION

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 A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED	
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F 600	§483.12(a)(1) Not physical abuse, co involuntary seclus This REQUIREME by: Based on intervie facility failed to pro of 3 residents (R1 incident of employ occurred. Findings include: R1's annual Minim 12/1/20, identified had a diagnoses of Sclerosis, depress The MDS indicate assistance with m (ADL's) which inclusion of the second of the	use verbal, mental, sexual, or orporal punishment, or ion; ENT is not met as evidenced w and document review, the ovide freedom from abuse for 1) reviewed for abuse when an ree to resident verbal abuse num Data Set (MDS) dated R1 was cognitively intact and which included Multiple sion and adjustment disorder. d R1 required extensive ost activities of daily living uded bed mobility, transfers, ing, eating, toileting, personal ng. The MDS identified R1 did always incontinent of bowel and Area Assessment (CAA) dated R1 required extensive ost ADL's which included bed locomotion, dressing, eating, hygiene and bathing. The CAA always incontinent of urine and rised 12/2/20, identified R1 was with a goal to keep R1 free elf and others. R1's care plan	F 60	Tag: F600 Free from Abu 483.12 Corrective action to reside affected: Conversation wit conducted immediately to felt safe in the facility and him to bring any concerns immediately. How the facility identified potential to be affected: A other residents to assure occurred. Measures put in place to e recur: Education to staff of defined as abuse and how How the facility will monitor performance to ensure so sustained: Audits will be of weekly x 4 weeks then Momonths. After completion be reviewed at the QAPI of determined if additional at necessary based on finding Responsible Persons: RN Managers/Supervisors/Din Nursing/Social Services A	ent found to be th (R1) assure resident to encourage to us other residents audit done on no abuse had ensure it will not on what is a to report. For its conducted conthly x3 of audits it will meeting and udits are ngs.		
	from harm from se identified he requi				Administrator.		

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 600	R1's care plan indice be verbally aggress mental/ emotional instruct about care and actionstructed staff to make the winstructed staff to each of the plan indicated staff to each of the plan indicated two sproviding cares due accusations agains. On 1/4/21, at 12:18 wheeled himself into wheelchair around in his wheelchair. Fourse words to him not recall the exact said the curse words to him not recall the exact said the curse words and the curse words are ported it to staff was not sure which on 1/4/21, at 2:22 plicensed practical in worked on 12/28/20 p.m. shift. LPN-A wroom when LPN-B up to R1's doorway yelled at LPN-B "you LPN-B appeared we responded back us she spoke to R1. LLPN-B should not be LPN-A was not able used by LPN-B but	a mechanical lift for transfers. cated R1 had the potential to sive towards staff related to liness and past traumatic ed staff to give R1 choices vities. R1's care plan further ot attempt to reason with R1 erbally aggressive and insure R1's safety, made sure t and to leave his room after would return later. R1's care staff would be in room when e to history of R1 making	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 600	the night. LPN-A coconstituted verbal add not report the in and stated LPN-B verbal stated LPN-B verbal stated she was not have been reported incident realized it is should have been reported incident realized it is should have been repending the full invertaining on abuse a management prior. On 1/4/21, at 2:34 perbal LPN-B confirmed some 2:00 p.m. to 10:15 perbal week due to low center had been going we doorway with her madded to state the state of the s	ge 3 ssumed care for R1 the rest of onfirmed swearing at a resident abuse. LPN-A confirmed she cident to anyone in the facility wrote details of the incident in book which was stored at the I-A stated at the time of the ot aware the incident should and after reflecting on the constituted verbal abuse and eported immediately. LPN-A loved from the schedule estigation and completed and neglect and behavior to returning back to work. In during an interview the worked on 12/28/20, on the form. shift after being off for a long. LPN-B stated her shift when she stopped at R1's led cart at around 8:00 p.m. on m his medications. LPN-B as present in R1's room. and, "finally you get here". LPN do into his room and R1 stated en on for a long time. LPN-B had got there as soon as they at about that guy?", and R1 said to LPN-B, "you were storthe last 30 minutes." tivities staff had been in there ated, "you should be fucking med she said to R1, "I haven't king week!", and stated she situation well". LPN-B stated and documented the ehavior notebook at the I-B stated she felt the need to	F6	600			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	COM	E SURVEY PLETED
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F 600	a super positive ou LPN-B confirmed it swear at R1 and co abuse. LPN-B state removed from the streepived training or behavior managem LPN-B stated she could give R1 stated, "Yeah I'n here." He said, "my last 30 minutes, who LPN-B stated to R1 could." R1 then said. LPN-B stated to R1 could." R1 then said. LPN-B stated, "who neighbor and LPN-R1 said, "you've behim for the past hor R1 it was not her behad been in there. It hat you should be responded back, "I fucking week." R1 said want me to treat yo speak to you how y left the room and R1.	her co-workers and never had tlook going into R1's room. was "very wrong" of her to onfirmed it was a form of verballed the next day she was schedule, was counseled and nabuse and neglect and hent prior to returning to work. did not report it to anyone. I LPN-B arrived at R1's room at cart to give R1 his pills. LPN-A his feet up. As soon as corway and she tried to ask if his pills R1 interrupted LPN-B LPN-B was very confused as an mad at her before like that, an talking to you lady, get in a talking to you lady. The same as soon as we do, "what about that guy?" It we got here as soon as we do, "what about that guy?" It referred to his B asked R1 what about him? Hen sitting in there talking to bur!" LPN-B tried to explain to but an activity staff person who R1 then said, "What I think is fucking fired!" LPN-B haven't even been here for a said, "Don't you fucking swear I, "You swore at me first, if you we like an equal then I will you speak to me." LPN-B then at asked other staff members to licensure information.	F 6	100			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		` ´COM	E SURVEY IPLETED
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F 600	dated 12/29/20, ind communication betwas reported on 12 12/28/20. The staff pending the investig safe. Review of the facility safe. Review of the facility and administrator, and administrator, and administrator, and administrator, and administer stated, "You've beefor the past hour." Let room at the time. List was not her in that responded, "What I fucking fired." LPN-for a fucking week! swear at me." LPN-vulnerable adult (V/was suspended per interviewed and state exchanged by both in the facility was cour for both LPN-B and work. The facility in residing on that units taff members. LPN in the past. Other sistaying calm, making walking away from	nome incident report (NHIR) icated inappropriate ween a nurse and resident /29/20, which occurred on member was suspended gation and the resident was y's internal investigation 31/20, identified on 12/29/20, y staff which included the DON were informed of the entry vior management notebook. ated LPN-B went into R1's his medications and R1 in sitting in there talking to him LPN-A was present in R1's PN-B explained to R1 that it room but an activity aid. R1 think is that you should be B said, "I haven't been here 'R1 said, "Don't you fucking B then left R1's room. A A) report was filed and LPN-B inding investigation. R1 was ted, "harsh words were of us". R1 stated he felt safe A and LPN-B were interviewed incident. The action taken by inseling and corrective action LPN-A before returning to terviewed several residents and had no disciplinary action taff received education about ing sure a resident is safe, and a resident displaying vior. The staff received	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER JEL NURSING HOME	:		STREET ADDRESS, CITY, STATE, ZIP CO 1415 MADISON AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	education on reporneglect to a supervention of the psychologist spin portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of appraddition to acknow R1 may be enactin Review of the psychologist spim portance of the psychologist spim portance of appraddition and that was a the door. R1 was considered to continue refused to continue get into an apartment of 1/4/21, during a licensed social working with and offered further R1 had declined. L behavior notebook morning of 12/29/2 LPN-B on 12/28/20 administration review form of verbal abuse tiled. The LSW pending the investit to complete training the spirit reports of the psychologist spim portance of the psych	ting any possible abuse or risor immediately. chologist progress note dated R1 had an adjustment disorder conduct and emotions and lisorder. The note identified R1 sues with his father from the acted him. The note identified boke with facility staff about the copriate boundaries with R1 in ledging the potential patterns g based on his history. chosocial assessment dated R1 was a vulnerable adult but reatment. The assessment een attacked in the past by two why he liked to face people or laustrophobic due to an een in the past. R1 had been psychology services but being seen. R1's goal was to	F 60	00		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245489	B. WING			1	04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			14	REET ADDRESS, CITY, STATE, ZIP CODE 15 MADISON AVENUE ETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	the investigation of was interviewed an happened. LSW sta on the unit were introncerns. LSW sta staff to see if they have to that incident in the On 1/4/21, at 3:15 puthe DON she stated were free from any stated she had bee morning on 12/29/2 completed by LPN-communication occopon confirmed the swearing and was a LPN-B to R1. DON report shortly after attention. DON state had her come into the assigned required eand behavior manathe same corrective DON stated all staff assigned education reporting all allegated. On 1/4/21, at 3:48 padministrator stated LSW brought a condadministrator reviews should be filed. The involved were removed to all supported to all supp	the incident. LSW stated R1 d R1 confirmed what had ated other residents residing erviewed and they had no ated they interviewed other had witnessed anything similar he past and no one had. D.m. during an interview with d it was expected all residents abuse within the facility. DON informed sometime on the 10, of the written entry B. DON stated inappropriate curred between LPN-B and R1. It communication involved a form of verbal abuse from stated the facility filed a VA the incident was brought to her led she contacted LPN-B and he facility to be counseled and education on abuse training gement training. DON stated action was taken for LPN-A. If who worked on the unit were about caring for R1 and	F 6	00			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245489	B. WING			C 04/2021	
NAME OF F	PROVIDER OR SUPPLIER	2.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	04/2021	
EMMANU	JEL NURSING HOME			1415 MADISON AVENUE DETROIT LAKES, MN 56501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		_D BE	(X5) COMPLETION DATE	
F 600	Facilities revised 11 residing in the facili abuse and neglect. abuse as a form of verbal abuse as the gestured language disparaging and de their families, or wit	ge 8 Minnesota Skilled Nursing I/17, indicated all residents ty would be protected from The policy identified verbal abuse. The policy defined e use of oral, written, or that willfully includes rogatory terms to residents or thin their hearing distance, age, ability to comprehend, or	F6	500			
	neglect, exploitation must: §483.12(c)(1) Ensure involving abuse, nemistreatment, inclusioning and misappeare reported immediate that cause the allegations bodily injury the events that cause and do not rethe administrator of officials (including to	onse to allegations of abuse, in, or mistreatment, the facility are that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events pation involve abuse or result in any, or not later than 24 hours if see the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency	F6			2/9/21	
	provides for jurisdic facilities) in accorda established procedu §483.12(c)(4) Repo investigations to the						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245489	B. WING		1)4/2021	
	PROVIDER OR SUPPLIER JEL NURSING HOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 609	accordance with St Survey Agency, wit incident, and if the appropriate correct This REQUIREMED by: Based on interview facility failed to ensito resident abuse with administrator at two hours, reported 1 of 3 residents (Rabuse. Findings include: R1's annual Minimus 12/1/20, identified I had a diagnoses with Sclerosis, depressi The MDS indicated assistance with mo (ADL's) which inclusion locomotion, dressir hygiene and bathin not walk and was a bladder. R1's annual Care A 12/8/20, identified I assistance with mo mobility, transfers, toileting, personal I identified R1 was a bowel.	ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced and document review, the ure an alleged violation of staff was immediately reported to and immediately, no later than it to the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) for 1) reviewed for allegations of the State Agency (SA) dated R1 required extensive in the State Agency (SA) dated R1 required extensive is ADL's which included bed locomotion, dressing, eating, nygiene and bathing. The CAA Iways incontinent of urine and	F 609	Tag: F609 reporting of alleged violation of the common affected: VA report was filed immerafter DON and Administrator were notified. How the facility identified other resipotential to be affected: Audit done other residents to assure no further had occurred and reporting was dotimely. Measures put in place to ensure it recur: Education to staff on who to any suspected abuse (noting that the Administrator must always be aware Education also on the timeframe of reporting and specifically suspected abuse is to be reported immediated meaning no longer than 2 hours frow becoming aware of the situation. How the facility will monitor its performance to ensure solutions and sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits be reviewed at the QAPI meeting and determined if additional audits are	to be diately idents on rabuse one will not report he re). f d ly, om		
	a vulnerable adult v	sed 12/2/20, identified R1 was with a goal to keep R1 free If and others. R1's care plan		necessary based on findings. Responsible Persons: RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245489	B. WING			C / 04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP C 1415 MADISON AVENUE DETROIT LAKES, MN 56501		70-172021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	identified he require most ADL's which is required the use of R1's care plan indicate verbally aggress mental/ emotional is events and instructed about care and actionstructed staff to maken he became with the plan indicated two sproviding R1 they will plan indicated two sproviding cares due accusations agains On 1/4/21, at 12:22 licensed practical in was present in R1's LPN-A arrived at R yelled at LPN-B "you LPN-B appeared were sponded back us she spoke to R1. L LPN-B should not be LPN-A was not able used by LPN-B but word "fucking". LPN resident constituted confirmed she did in anyone in the facility details of the incident and after reflecting and staff and after reflecting in the facility and	ed extensive assistance with included dressing, toileting and a mechanical lift for transfers. Cated R1 had the potential to sive towards staff related to llness and past traumatic ed staff to give R1 choices vities. R1's care plan further of attempt to reason with R1 erbally aggressive and insure R1's safety, made sure than to leave his room after would return later. R1's care staff would be in room when ento history of R1 making it staff. It p.m. during an interview the urise (LPN)-A confirmed she is room on 12/28/20, when 1's room. LPN-A stated R1 is should be fucking fired and the ery upset, raised her voice and ing the word "fucking" when PN-A stated R1 responded to talking to him like that. The to recall the exact statement and remember her using the N-A confirmed swearing at a diverbal abuse. LPN-A the transfer to report the incident to be and stated LPN-B wrote ent in R1's behavior notebook at the nurses station. LPN-A of the incident she was not should have been reported on the incident realized it abuse and should have been	F 609	Managers/Supervisors/Direct Nursing/Social Services Adria Date of completion: Februar	ministrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245489	B. WING_		01	C / 04/2021	
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COL 1415 MADISON AVENUE DETROIT LAKES, MN 56501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 609	LPN-B stated on 12 at her, "you should confirmed she said a fucking week!", a the situation well". I room and documer behavior notebook stated she felt the I co-workers and ne outlook going into f was "very wrong" or confirmed it was a confirmed she did I anyone. Review of R1's behrevealed the follow 12/28/20: The entry identified 8:00 p.m. with her owas helping R1 put LPN-B got in the do she could give R1 and started yelling.	p.m. during an interview 2/28/20, at 8:00 p.m. R1 yelled be fucking fired." LPN-B to R1, "I haven't been here for nd stated she did not "handle LPN-B stated she left R1's at the nurses station. LPN-B need to defend herself and her ver had a super positive R1's room. LPN-B confirmed it form of verbal abuse. LPN-B not report the incident to avior management notebook ing entry by LPN-B on at cart to give R1 his pills. LPN-A this feet up. As soon as porway and she tried to ask if his pills R1 interrupted LPN-B LPN-B was very confused as an mad at her before like that.	F 60	,			
	here." He said, "my last 30 minutes, wh LPN-B stated to R7 could." R1 then sai LPN-B stated, "wha neighbor and LPN-R1 said, "you've be him for the past ho R1 it was not her b had been in there.	m talking to you lady, get in a light has been on for for the nat's going on around here?" I, "we got here as soon as we d, "what about that guy?" at guy?" R1 referred to his B asked R1 what about him? Hen sitting in there talking to ur!" LPN-B tried to explain to ut an activity staff person who R1 then said, "What I think is fucking fired!" LPN-B					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245489	B. WING		0	C 1/04/2021
	PROVIDER OR SUPPLIER UEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 1415 MADISON AVENUE DETROIT LAKES, MN 56501		170-172-02-1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	responded back, "I fucking week." R1 sat me!" LPN-B said want me to treat yo speak to you how y left the room and R for LPN-B's nursing. Review of nursing hated 12/29/20, ind communication bet was reported on 12 and the allegation of evening shift. On 1/4/21, during a licensed social wor R1's behavior notel morning of 12/29/20 LPN-B on 12/28/20 facility administration was a form of verba adult (VA) report noted to morning of 12/29/20, at 3:15 pure director of nursibeen informed som 12/29/20, of the writ LPN-B. DON stated occurred between I confirmed the command was a form of R1. DON stated the shortly after the incattention. DON con on 12/28/20, at 8:00 report to the SA 12.	haven't even been here for a said, "Don't you fucking swear, "You swore at me first, if you u like an equal then I will ou speak to me." LPN-B then 1 asked other staff members glicensure information. nome incident report (NHIR) icated inappropriate ween a nurse and resident 1/29/20 at 12:24 p.m. to the SA occurred on 12/28/20 on the on interview at 3:06 p.m. ker (LSW) stated staff brought book to her sometime on the 0, to show the entry made by at 8:00 p.m. LSW stated the on reviewed it and confirmed it all abuse and a vulnerable	F6	09		

AND DUAN OF CORRECTION DENTIFICATION NUMBER.		l ' '	TIPLE CONSTRUCTION ING	COM	(X3) DATE SURVEY COMPLETED	
		245489	B. WING			C / 04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, 2 1415 MADISON AVENUE DETROIT LAKES, MN 56501	ZIP CODE	104/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	was not reported tir frame. DON stated allegations of abuse than two hours after than two hours at the LSW brought a condition of administrator responded by the filed. The allegation of abuse SA within the two hexpected all staff to timely. Review of the facility Prevention Plan For Facilities dated 11/2 a form of maltreatm to report suspected immediately and not stated than the facility and not support that the facility and th	mely within the two hour time it was expected all staff report in the allegation occurred. I.m. during an interview the discontinue on 12/29/20, the cern forward for her to review. Eviewed it and felt a VA report in administrator confirmed the was not reported timely to the our time frame and stated she in report allegations of abuse of policy titled Ecumen's Abuse of Minnesota Skilled Nursing in it. The policy instructed staff in maltreatment to the SA in later than two hours after the atment occurred if it involved.	F 6	609		

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 03/01/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245489	B. WING				/ 04/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EMMANU	JEL NURSING HOME				15 MADISON AVENUE ETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 0	000			
		result of MDH's Informal and/or Quality Assurance					
	at your facility to co investigation. Your f	facility was found not to be in CFR Part 483, Requirements					
	The following comp substantiated: H5489029C.	plaint was found to be					
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 609	on-site revisit of you validate that substa regulations has bee your verification. Reporting of Alleger		F 6	809			2/9/21
SS=D	§483.12(c) In respo	1)(4) onse to allegations of abuse, n, or mistreatment, the facility					
	involving abuse, ne	re that all alleged violations glect, exploitation or ding injuries of unknown					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						01/20/2021

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		PLETED
		245489	B. WING			01/0	04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 609	are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not rethe administrator of officials (including tadult protective ser for jurisdiction in los accordance with St procedures. §483.12(c)(4) Repositive stigations to the designated represe accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by: Based on interview facility failed to ensity to resident abuse with administrator at two hours, reported.	ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established	F 6	609	Tag: F609 reporting of alleged viole Corrective action to resident found affected: VA report was filed immed after DON and Administrator were notified. How the facility identified other residents to be affected: Audit done of the residents to secure as further than the residents to secure as the resident to secure as the resid	to be diately dents on	
	12/1/20, identified F had a diagnoses wh Sclerosis, depressi The MDS indicated	um Data Set (MDS) dated R1 was cognitively intact and nich included Multiple on and adjustment disorder. R1 required extensive st activities of daily living			other residents to assure no further had occurred and reporting was do timely. Measures put in place to ensure it recur: Education to staff on who to any suspected abuse (noting that the	ne will not report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245489	B. WING			C 04/2021	
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, Z 1415 MADISON AVENUE DETROIT LAKES, MN 56501	IP CODE	V-112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 609	locomotion, dressin hygiene and bathir not walk and was a bladder. R1's annual Care A 12/8/20, identified assistance with momobility, transfers, toileting, personal identified R1 was a bowel. R1's care plan revia a vulnerable adult from harm from seidentified he require most ADL's which required the use of R1's care plan indibe verbally aggres mental/ emotional events and instructed staff to rewhen he became winstructed staff to rewhen he became winstructed staff to R1 had his call light informing R1 they plan indicated two providing cares du accusations agains On 1/4/21, at 12:22 licensed practical rewas present in R1'LPN-A arrived at R1	aided bed mobility, transfers, ng, eating, toileting, personal ng. The MDS identified R1 did always incontinent of bowel and Area Assessment (CAA) dated R1 required extensive bet ADL's which included bed locomotion, dressing, eating, hygiene and bathing. The CAA always incontinent of urine and seed 12/2/20, identified R1 was with a goal to keep R1 free If and others. R1's care plan ed extensive assistance with included dressing, toileting and f a mechanical lift for transfers. Cated R1 had the potential to sive towards staff related to illness and past traumatic ted staff to give R1 choices ivities. R1's care plan further not attempt to reason with R1 verbally aggressive and ensure R1's safety, made sure at and to leave his room after would return later. R1's care staff would be in room when e to history of R1 making	F 6	Administrator must alwa Education also on the tir reporting and specifically abuse is to be reported i meaning no longer than becoming aware of the second was also as the second was a	neframe of y suspected mmediately, 2 hours from situation. tor its colutions are conducted Monthly x3 n of audits it will meeting and audits are ings. N Director of Administrator.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245489	B. WING				C 04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501	1 01/1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 609	responded back usishe spoke to R1. LFLPN-B should not be LPN-A was not able used by LPN-B but word "fucking". LPN resident constituted confirmed she did ranyone in the facilit details of the incide which was stored a stated at the time of aware the incidents and after reflecting constituted verbal areported immediate. On 1/4/21, at 2:34 per LPN-B stated on 12 at her, "you should confirmed she said a fucking week!", at the situation well". Let room and document behavior notebook stated she felt the reco-workers and new outlook going into Fer was "very wrong" of confirmed it was a fer confirmed she did ranyone. Review of R1's behave revealed the following 12/28/20: The entry identified.	ery upset, raised her voice and ing the word "fucking" when PN-A stated R1 responded the talking to him like that. It to recall the exact statement did remember her using the IN-A confirmed swearing at a liverbal abuse. LPN-A not report the incident to by and stated LPN-B wrote int in R1's behavior notebook at the nurses station. LPN-A for the incident she was not should have been reported on the incident realized it inbuse and should have been	F6	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COM	E SURVEY IPLETED
		245489	B. WING				C 04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			1415 MADISON	SS, CITY, STATE, ZIP CODE AVENUE (ES, MN 56501	<u>, </u>	0.112021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (VIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUI REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	was helping R1 put LPN-B got in the do she could give R1 hand started yelling. R1 had never gotte R1 stated, "Yeah I'n here." He said, "my last 30 minutes, wh LPN-B stated to R1 could." R1 then said LPN-B stated, "whan eighbor and LPN-IR1 said, "you've be him for the past hou R1 it was not her but had been in there. If that you should be responded back, "I fucking week." R1 sat me!" LPN-B said want me to treat yo speak to you how y left the room and R for LPN-B's nursing Review of nursing hated 12/29/20, ind communication betwas reported on 12 and the allegation of evening shift. On 1/4/21, during a licensed social worl R1's behavior noted morning of 12/29/20 facility administration.	his feet up. As soon as porway and she tried to ask if his pills R1 interrupted LPN-B LPN-B was very confused as an mad at her before like that. In talking to you lady, get in light has been on for for the at's going on around here?", "we got here as soon as we d, "what about that guy?" It guy?" R1 referred to his B asked R1 what about him? en sitting in there talking to ur!" LPN-B tried to explain to ut an activity staff person who R1 then said, "What I think is fucking fired!" LPN-B haven't even been here for a said, "Don't you fucking swear, "You swore at me first, if you ut like an equal then I will out speak to me." LPN-B then 1 asked other staff members alicensure information. In ome incident report (NHIR) incated inappropriate ween a nurse and resident (29/20 at 12:24 p.m. to the SA occurred on 12/28/20 on the continuous of the continuous of the latest and confirmed it all abuse and a vulnerable was and a vulnerable	Fé	09			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED
		245489	B. WING _		01	C / 04/2021
	PROVIDER OR SUPPLIER UEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501	<u>, , , , , , , , , , , , , , , , , , , </u>	104/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	adult (VA) report new On 1/4/21, at 3:15 pthe director of nursibeen informed som 12/29/20, of the writh LPN-B. DON stated occurred between It confirmed the command was a form of R1. DON stated the shortly after the incattention. DON con on 12/28/20, at 8:00 report to the SA 12/2 hours and 24 minutoccurred. DON con was not reported tir frame. DON stated allegations of abuse than two hours after the domain of administrator stated LSW brought a con The administrator reshould be filed. The allegation of abuse SA within the two he expected all staff to timely. Review of the facility Prevention Plan For Facilities dated 11/2 form of maltreatme to report suspected immediately and not stated to the suspected immediately and not suspected immediately and	_	F 60			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	COM	E SURVEY PLETED
		245489	B. WING _			C 04/2021
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501		0-4/2-02 T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	Continued From pa abuse.	ge 6	F 60			