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.

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

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.

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

DEPARTMENT OF HEALTH

*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

DEPARTMENT OF HEALTH

*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

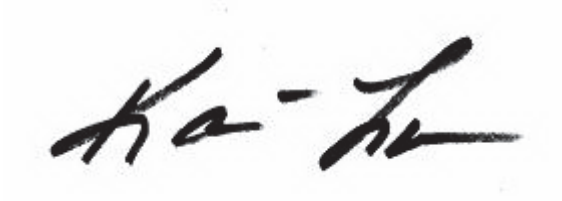
Dear Danielle:

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00013 | A. BUILDING: _____ B. WING _____ | C 01/04/2021 |

| 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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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 1/4/21, a surveyor of this Department's staff visited the above provider for a complaint investigation and no correction order was issued.<br><br>The following complaint was found to be substantiated:<br>H5489029C with no licensing order issued. | 2 000 | | |

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

Electronically Signed | 01/20/21

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| 2 000 | Continued From page 1<br><br>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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.<br><br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |

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| F 000 | INITIAL COMMENTS<br><br>On 1/4/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated:<br>H5489029C.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must- | F 600 | | 2/9/21 |

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

Electronically Signed | 01/20/2021

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 600 | Continued From page 1<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide freedom from abuse for 1 of 3 residents (R1) reviewed for abuse when an incident of employee to resident verbal abuse occurred.<br><br>Findings include:<br><br>R1's annual Minimum Data Set (MDS) dated 12/1/20, identified R1 was cognitively intact and had a diagnoses which included Multiple Sclerosis, depression and adjustment disorder. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The MDS identified R1 did not walk and was always incontinent of bowel and bladder.<br><br>R1's annual Care Area Assessment (CAA) dated 12/8/20, identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The CAA identified R1 was always incontinent of urine and bowel.<br><br>R1's care plan revised 12/2/20, identified R1 was a vulnerable adult with a goal to keep R1 free from harm from self and others. R1's care plan identified he required extensive assistance with most ADL's which included dressing, toileting and | F 600 | Tag: F600 Free from Abuse and Neglect 483.12<br><br>Corrective action to resident found to be affected: Conversation with (R1) conducted immediately to assure resident felt safe in the facility and to encourage him to bring any concerns to us immediately.<br><br>How the facility identified other residents potential to be affected: Audit done on other residents to assure no abuse had occurred.<br><br>Measures put in place to ensure it will not recur: Education to staff on what is defined as abuse and how to report.<br><br>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.<br><br>Responsible Persons: RN Managers/Supervisors/Director of Nursing/Social Services Administrator.<br><br>Date of completion: February, 9, 2021 | |

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| F 600 | Continued From page 2 | F 600 | | |

required the use of a mechanical lift for transfers. R1's care plan indicated R1 had the potential to be verbally aggressive towards staff related to mental/ emotional illness and past traumatic events and instructed staff to give R1 choices about care and activities. R1's care plan further instructed staff to not attempt to reason with R1 when he became verbally aggressive and instructed staff to ensure R1's safety, made sure R1 had his call light and to leave his room after informing R1 they would return later. R1's care plan indicated two staff would be in room when providing cares due to history of R1 making accusations against staff.

On 1/4/21, at 12:18 p.m. during an interview R1 wheeled himself into his room turned his wheelchair around to face the door and remained in his wheelchair. R1 confirmed staff had said curse words to him in the recent past and could not recall the exact date or which staff person said the curse words to him. R1 stated he had reported it to staff who worked in the facility and was not sure which staff he had reported it to.

On 1/4/21, at 2:22 p.m. during an interview licensed practical nurse (LPN)-A stated she worked on 12/28/20, on the 2:00 p.m. to 10:15 p.m. shift. LPN-A verified she was present in R1's room when LPN-B wheeled her medication cart up to R1's doorway sometime that evening. R1 yelled at LPN-B "you should be fucking fired" and LPN-B appeared very upset, raised her voice and responded back using the word "fucking" when she spoke to R1. LPN-A stated R1 responded LPN-B should not be talking to him like that. LPN-A was not able to recall the exact statement used by LPN-B but did remember her using the word "fucking". LPN-A indicated LPN-B left the

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| F 600 | Continued From page 3 | F 600 | | |

room and LPN-A assumed care for R1 the rest of the night. LPN-A confirmed swearing at a resident constituted verbal abuse. LPN-A confirmed she did not report the incident to anyone in the facility and stated LPN-B wrote details of the incident in R1's behavior notebook which was stored at the nurses station. LPN-A stated at the time of the incident she was not aware the incident should have been reported and after reflecting on the incident realized it constituted verbal abuse and should have been reported immediately. LPN-A stated she was removed from the schedule pending the full investigation and completed training on abuse and neglect and behavior management prior to returning back to work.

On 1/4/21, at 2:34 p.m. during an interview LPN-B confirmed she worked on 12/28/20, on the 2:00 p.m. to 10:15 p.m. shift after being off for a week due to low census. LPN-B stated her shift had been going well when she stopped at R1's doorway with her med cart at around 8:00 p.m. on 12/28/20, to give him his medications. LPN-B indicated LPN-A was present in R1's room. LPN-B stated R1 said, "finally you get here". LPN B stated she walked into his room and R1 stated his call light had been on for a long time. LPN-B responded the staff had got there as soon as they could. R1 said, "what about that guy?", and pointed at his wall. R1 said to LPN-B, "you were in there on your ass for the last 30 minutes." LPN-B indicated activities staff had been in there not her. R1 then stated, "you should be fucking fired." LPN-B confirmed she said to R1, "I haven't been here for a fucking week!", and stated she did not "handle the situation well". LPN-B stated she left R1's room and documented the encounter in R1's behavior notebook at the nurses station. LPN-B stated she felt the need to

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| F 600 | Continued From page 4 | F 600 | | |

defend herself and her co-workers and never had a super positive outlook going into R1's room. LPN-B confirmed it was "very wrong" of her to swear at R1 and confirmed it was a form of verbal abuse. LPN-B stated the next day she was removed from the schedule, was counseled and received training on abuse and neglect and behavior management prior to returning to work. LPN-B stated she did not report it to anyone.

Review of R1's behavior management notebook revealed the following entry by LPN-B on 12/28/20:
The entry identified LPN-B arrived at R1's room at 8:00 p.m. with her cart to give R1 his pills. LPN-A was helping R1 put his feet up. As soon as LPN-B got in the doorway and she tried to ask if she could give R1 his pills R1 interrupted LPN-B and started yelling. LPN-B was very confused as R1 had never gotten mad at her before like that. R1 stated, "Yeah I'm talking to you lady, get in here." He said, "my light has been on for for the last 30 minutes, what's going on around here?" LPN-B stated to R1, "we got here as soon as we could." R1 then said, "what about that guy?" LPN-B stated, "what guy?" R1 referred to his neighbor and LPN-B asked R1 what about him? R1 said, "you've been sitting in there talking to him for the past hour!" LPN-B tried to explain to R1 it was not her but an activity staff person who had been in there. R1 then said, "What I think is that you should be fucking fired!" LPN-B responded back, "I haven't even been here for a fucking week." R1 said, "Don't you fucking swear at me!" LPN-B said, "You swore at me first, if you want me to treat you like an equal then I will speak to you how you speak to me." LPN-B then left the room and R1 asked other staff members for LPN-B's nursing licensure information.

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

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| F 600 | Continued From page 5 | F 600 | | |

Review of nursing home incident report (NHIR) dated 12/29/20, indicated inappropriate communication between a nurse and resident was reported on 12/29/20, which occurred on 12/28/20. The staff member was suspended pending the investigation and the resident was safe.

Review of the facility's internal investigation summary dated 12/31/20, identified on 12/29/20, at 10:30 a.m. facility staff which included the DON and administrator, were informed of the entry noted in R1's behavior management notebook. The written entry stated LPN-B went into R1's room to administer his medications and R1 stated, "You've been sitting in there talking to him for the past hour." LPN-A was present in R1's room at the time. LPN-B explained to R1 that it was not her in that room but an activity aid. R1 responded, "What I think is that you should be fucking fired." LPN-B said, "I haven't been here for a fucking week!" R1 said, "Don't you fucking swear at me." LPN-B then left R1's room. A vulnerable adult (VA) report was filed and LPN-B was suspended pending investigation. R1 was interviewed and stated, "harsh words were exchanged by both of us". R1 stated he felt safe in the facility. LPN-A and LPN-B were interviewed and confirmed the incident. The action taken by the facility was counseling and corrective action for both LPN-B and LPN-A before returning to work. The facility interviewed several residents residing on that unit and had no concerns with staff members. LPN-B had no disciplinary action in the past. Other staff received education about staying calm, making sure a resident is safe, and walking away from a resident displaying inappropriate behavior. The staff received

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education on reporting any possible abuse or neglect to a supervisor immediately.

Review of the psychologist progress note dated 6/11/20, indicated R1 had an adjustment disorder with disturbance of conduct and emotions and major depressive disorder. The note identified R1 had relationship issues with his father from the past which still affected him. The note identified the psychologist spoke with facility staff about the importance of appropriate boundaries with R1 in addition to acknowledging the potential patterns R1 may be enacting based on his history.

Review of the psychosocial assessment dated 9/28/20, identified R1 was a vulnerable adult but able to report maltreatment. The assessment indicated R1 had been attacked in the past by two men and that was why he liked to face people or the door. R1 was claustrophobic due to an explosion he had been in the past. R1 had been offered to continue psychology services but refused to continue being seen. R1's goal was to get into an apartment building.

On 1/4/21, during an interview at 3:06 p.m. licensed social worker (LSW) indicated she had been working with R1 on behavioral interventions and offered further psychological services which R1 had declined. LSW stated staff brought R1's behavior notebook to her sometime on the morning of 12/29/20, to show the entry made by LPN-B on 12/28/20. LSW stated the facility administration reviewed it and confirmed it was a form of verbal abuse and a VA report needed to be filed. The LSW stated LPN-B was suspended pending the investigation and indicated she had to complete training on abuse prevention prior to returning to work. LSW stated she assisted with

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| F 600 | Continued From page 7 | F 600 | | |

the investigation of the incident. LSW stated R1 was interviewed and R1 confirmed what had happened. LSW stated other residents residing on the unit were interviewed and they had no concerns. LSW stated they interviewed other staff to see if they had witnessed anything similar to that incident in the past and no one had.

On 1/4/21, at 3:15 p.m. during an interview with the DON she stated it was expected all residents were free from any abuse within the facility. DON stated she had been informed sometime on the morning on 12/29/20, of the written entry completed by LPN-B. DON stated inappropriate communication occurred between LPN-B and R1. DON confirmed the communication involved swearing and was a form of verbal abuse from LPN-B to R1. DON stated the facility filed a VA report shortly after the incident was brought to her attention. DON stated she contacted LPN-B and had her come into the facility to be counseled and assigned required education on abuse training and behavior management training. DON stated the same corrective action was taken for LPN-A. DON stated all staff who worked on the unit were assigned education about caring for R1 and reporting all allegations of abuse.

On 1/4/21, at 3:48 p.m. during an interview the administrator stated sometime on 12/29/20, the LSW brought a concern forward for review. The administrator reviewed it and felt a VA report should be filed. The administrator stated staff involved were removed from the schedule and were assigned necessary training before returning back to work. Additionally, the training was provided to all staff who worked on the unit.

Review of facility policy titled Ecumen's Abuse

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| F 600 | Continued From page 8<br>Prevention Plan for Minnesota Skilled Nursing Facilities revised 11/17, indicated all residents residing in the facility would be protected from abuse and neglect. The policy identified verbal abuse as a form of abuse. The policy defined verbal abuse as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in | F 609 | | 2/9/21 |

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| F 609 | Continued From page 9<br>accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure an alleged violation of staff to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.<br><br>Findings include:<br><br>R1's annual Minimum Data Set (MDS) dated 12/1/20, identified R1 was cognitively intact and had a diagnoses which included Multiple Sclerosis, depression and adjustment disorder. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The MDS identified R1 did not walk and was always incontinent of bowel and bladder.<br><br>R1's annual Care Area Assessment (CAA) dated 12/8/20, identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The CAA identified R1 was always incontinent of urine and bowel.<br><br>R1's care plan revised 12/2/20, identified R1 was a vulnerable adult with a goal to keep R1 free from harm from self and others. R1's care plan | F 609 | Tag: F609 reporting of alleged violations<br><br>Corrective action to resident found to be affected: VA report was filed immediately after DON and Administrator were notified.<br><br>How the facility identified other residents potential to be affected: Audit done on other residents to assure no further abuse had occurred and reporting was done timely.<br><br>Measures put in place to ensure it will not recur: Education to staff on who to report 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 immediately, meaning no longer than 2 hours from becoming aware of the situation.<br><br>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.<br><br>Responsible Persons: RN | |

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| F 609 | Continued From page 10<br>identified he required extensive assistance with most ADL's which included dressing, toileting and required the use of a mechanical lift for transfers. R1's care plan indicated R1 had the potential to be verbally aggressive towards staff related to mental/ emotional illness and past traumatic events and instructed staff to give R1 choices about care and activities. R1's care plan further instructed staff to not attempt to reason with R1 when he became verbally aggressive and instructed staff to ensure R1's safety, made sure R1 had his call light and to leave his room after informing R1 they would return later. R1's care plan indicated two staff would be in room when providing cares due to history of R1 making accusations against staff.<br><br>On 1/4/21, at 12:22 p.m. during an interview licensed practical nurse (LPN)-A confirmed she was present in R1's room on 12/28/20, when LPN-A arrived at R1's room. LPN-A stated R1 yelled at LPN-B "you should be fucking fired" and LPN-B appeared very upset, raised her voice and responded back using the word "fucking" when she spoke to R1. LPN-A stated R1 responded LPN-B should not be talking to him like that. LPN-A was not able to recall the exact statement used by LPN-B but did remember her using the word "fucking". LPN-A confirmed swearing at a resident constituted verbal abuse. LPN-A confirmed she did not report the incident to anyone in the facility and stated LPN-B wrote details of the incident in R1's behavior notebook which was stored at the nurses station. LPN-A stated at the time of the incident she was not aware the incident should have been reported and after reflecting on the incident realized it constituted verbal abuse and should have been reported immediately. | F 609 | Managers/Supervisors/Director of Nursing/Social Services Administrator.<br><br>Date of completion: February, 9, 2021 | |

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On 1/4/21, at 2:34 p.m. during an interview LPN-B stated on 12/28/20, at 8:00 p.m. R1 yelled at her, "you should be fucking fired." LPN-B confirmed she said to R1, "I haven't been here for a fucking week!", and stated she did not "handle the situation well". LPN-B stated she left R1's room and documented the encounter in R1's behavior notebook at the nurses station. LPN-B stated she felt the need to defend herself and her co-workers and never had a super positive outlook going into R1's room. LPN-B confirmed it was "very wrong" of her to swear at R1 and confirmed it was a form of verbal abuse. LPN-B confirmed she did not report the incident to anyone.

Review of R1's behavior management notebook revealed the following entry by LPN-B on 12/28/20:
The entry identified LPN-B arrived at R1's room at 8:00 p.m. with her cart to give R1 his pills. LPN-A was helping R1 put his feet up. As soon as LPN-B got in the doorway and she tried to ask if she could give R1 his pills R1 interrupted LPN-B and started yelling. LPN-B was very confused as R1 had never gotten mad at her before like that. R1 stated, "Yeah I'm talking to you lady, get in here." He said, "my light has been on for for the last 30 minutes, what's going on around here?" LPN-B stated to R1, "we got here as soon as we could." R1 then said, "what about that guy?" LPN-B stated, "what guy?" R1 referred to his neighbor and LPN-B asked R1 what about him? R1 said, "you've been sitting in there talking to him for the past hour!" LPN-B tried to explain to R1 it was not her but an activity staff person who had been in there. R1 then said, "What I think is that you should be fucking fired!" LPN-B

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| F 609 | Continued From page 12 | F 609 | | |

responded back, "I haven't even been here for a fucking week." R1 said, "Don't you fucking swear at me!" LPN-B said, "You swore at me first, if you want me to treat you like an equal then I will speak to you how you speak to me." LPN-B then left the room and R1 asked other staff members for LPN-B's nursing licensure information.

Review of nursing home incident report (NHIR) dated 12/29/20, indicated inappropriate communication between a nurse and resident was reported on 12/29/20 at 12:24 p.m. to the SA and the allegation occurred on 12/28/20 on the evening shift.

On 1/4/21, during an interview at 3:06 p.m. licensed social worker (LSW) stated staff brought R1's behavior notebook to her sometime on the morning of 12/29/20, to show the entry made by LPN-B on 12/28/20 at 8:00 p.m. LSW stated the facility administration reviewed it and confirmed it was a form of verbal abuse and a vulnerable adult (VA) report needed to be filed.

On 1/4/21, at 3:15 p.m. during an interview with the director of nursing (DON) she stated she had been informed sometime on the morning on 12/29/20, of the written entry completed by LPN-B. DON stated inappropriate communication occurred between LPN-B and R1. DON confirmed the communication involved swearing and was a form of verbal abuse from LPN-B to R1. DON stated the facility filed a VA report shortly after the incident was brought to her attention. DON confirmed the allegation occurred on 12/28/20, at 8:00 p.m. and the facility filed the report to the SA 12/29/20, at 12:24 p.m. a full 16 hours and 24 minutes after the allegation occurred. DON confirmed the allegation of abuse

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| F 609 | Continued From page 13<br>was not reported timely within the two hour time frame. DON stated it was expected all staff report allegations of abuse immediately and no later than two hours after the allegation occurred.<br><br>On 1/4/21, at 3:48 p.m. during an interview the administrator stated sometime on 12/29/20, the LSW brought a concern forward for her to review. The administrator reviewed it and felt a VA report should be filed. The administrator confirmed the allegation of abuse was not reported timely to the SA within the two hour time frame and stated she expected all staff to report allegations of abuse timely.<br><br>Review of the facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities dated 11/17, identified verbal abuse as a form of maltreatment. The policy instructed staff to report suspected maltreatment to the SA immediately and no later than two hours after the allegation of maltreatment occurred if it involved abuse. | F 609 | | |

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| F 000 | INITIAL COMMENTS<br><br>Revised 2567 as a result of MDH's Informal Dispute Resolution and/or Quality Assurance review.<br><br>On 1/4/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated:<br>H5489029C.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown | F 609 | | 2/9/21 |

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

Electronically Signed | 01/20/2021

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| F 609 | Continued From page 1<br>source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure an alleged violation of staff to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.<br><br>Findings include:<br><br>R1's annual Minimum Data Set (MDS) dated 12/1/20, identified R1 was cognitively intact and had a diagnoses which included Multiple Sclerosis, depression and adjustment disorder. The MDS indicated R1 required extensive assistance with most activities of daily living | F 609 | Tag: F609 reporting of alleged violations<br><br>Corrective action to resident found to be affected: VA report was filed immediately after DON and Administrator were notified.<br><br>How the facility identified other residents potential to be affected: Audit done on other residents to assure no further abuse had occurred and reporting was done timely.<br><br>Measures put in place to ensure it will not recur: Education to staff on who to report any suspected abuse (noting that the | |

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| F 609 | Continued From page 2<br>(ADL's) which included bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The MDS identified R1 did not walk and was always incontinent of bowel and bladder.<br><br>R1's annual Care Area Assessment (CAA) dated 12/8/20, identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing. The CAA identified R1 was always incontinent of urine and bowel.<br><br>R1's care plan revised 12/2/20, identified R1 was a vulnerable adult with a goal to keep R1 free from harm from self and others. R1's care plan identified he required extensive assistance with most ADL's which included dressing, toileting and required the use of a mechanical lift for transfers. R1's care plan indicated R1 had the potential to be verbally aggressive towards staff related to mental/ emotional illness and past traumatic events and instructed staff to give R1 choices about care and activities. R1's care plan further instructed staff to not attempt to reason with R1 when he became verbally aggressive and instructed staff to ensure R1's safety, made sure R1 had his call light and to leave his room after informing R1 they would return later. R1's care plan indicated two staff would be in room when providing cares due to history of R1 making accusations against staff.<br><br>On 1/4/21, at 12:22 p.m. during an interview licensed practical nurse (LPN)-A confirmed she was present in R1's room on 12/28/20, when LPN-A arrived at R1's room. LPN-A stated R1 yelled at LPN-B "you should be fucking fired" and | F 609 | Administrator must always be aware). Education also on the timeframe of reporting and specifically suspected abuse is to be reported immediately, meaning no longer than 2 hours from becoming aware of the situation.<br><br>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.<br><br>Responsible Persons: RN Managers/Supervisors/Director of Nursing/Social Services Administrator.<br><br>Date of completion: February, 9, 2021 | |

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|---|---|---|---|
| | 245489 | A. BUILDING _____ B. WING _____ | C 01/04/2021 |

| 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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LPN-B appeared very upset, raised her voice and responded back using the word "fucking" when she spoke to R1. LPN-A stated R1 responded LPN-B should not be talking to him like that. LPN-A was not able to recall the exact statement used by LPN-B but did remember her using the word "fucking". LPN-A confirmed swearing at a resident constituted verbal abuse. LPN-A confirmed she did not report the incident to anyone in the facility and stated LPN-B wrote details of the incident in R1's behavior notebook which was stored at the nurses station. LPN-A stated at the time of the incident she was not aware the incident should have been reported and after reflecting on the incident realized it constituted verbal abuse and should have been reported immediately.

On 1/4/21, at 2:34 p.m. during an interview LPN-B stated on 12/28/20, at 8:00 p.m. R1 yelled at her, "you should be fucking fired." LPN-B confirmed she said to R1, "I haven't been here for a fucking week!", and stated she did not "handle the situation well". LPN-B stated she left R1's room and documented the encounter in R1's behavior notebook at the nurses station. LPN-B stated she felt the need to defend herself and her co-workers and never had a super positive outlook going into R1's room. LPN-B confirmed it was "very wrong" of her to swear at R1 and confirmed it was a form of verbal abuse. LPN-B confirmed she did not report the incident to anyone.

Review of R1's behavior management notebook revealed the following entry by LPN-B on 12/28/20:
The entry identified LPN-B arrived at R1's room at 8:00 p.m. with her cart to give R1 his pills. LPN-A

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was helping R1 put his feet up. As soon as LPN-B got in the doorway and she tried to ask if she could give R1 his pills R1 interrupted LPN-B and started yelling. LPN-B was very confused as R1 had never gotten mad at her before like that. R1 stated, "Yeah I'm talking to you lady, get in here." He said, "my light has been on for for the last 30 minutes, what's going on around here?" LPN-B stated to R1, "we got here as soon as we could." R1 then said, "what about that guy?" LPN-B stated, "what guy?" R1 referred to his neighbor and LPN-B asked R1 what about him? R1 said, "you've been sitting in there talking to him for the past hour!" LPN-B tried to explain to R1 it was not her but an activity staff person who had been in there. R1 then said, "What I think is that you should be fucking fired!" LPN-B responded back, "I haven't even been here for a fucking week." R1 said, "Don't you fucking swear at me!" LPN-B said, "You swore at me first, if you want me to treat you like an equal then I will speak to you how you speak to me." LPN-B then left the room and R1 asked other staff members for LPN-B's nursing licensure information.

Review of nursing home incident report (NHIR) dated 12/29/20, indicated inappropriate communication between a nurse and resident was reported on 12/29/20 at 12:24 p.m. to the SA and the allegation occurred on 12/28/20 on the evening shift.

On 1/4/21, during an interview at 3:06 p.m. licensed social worker (LSW) stated staff brought R1's behavior notebook to her sometime on the morning of 12/29/20, to show the entry made by LPN-B on 12/28/20 at 8:00 p.m. LSW stated the facility administration reviewed it and confirmed it was a form of verbal abuse and a vulnerable

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| F 609 | Continued From page 5<br>adult (VA) report needed to be filed.<br><br>On 1/4/21, at 3:15 p.m. during an interview with the director of nursing (DON) she stated she had been informed sometime on the morning on 12/29/20, of the written entry completed by LPN-B. DON stated inappropriate communication occurred between LPN-B and R1. DON confirmed the communication involved swearing and was a form of verbal abuse from LPN-B to R1. DON stated the facility filed a VA report shortly after the incident was brought to her attention. DON confirmed the allegation occurred on 12/28/20, at 8:00 p.m. and the facility filed the report to the SA 12/29/20, at 12:24 p.m. a full 16 hours and 24 minutes after the allegation occurred. DON confirmed the allegation of abuse was not reported timely within the two hour time frame. DON stated it was expected all staff report allegations of abuse immediately and no later than two hours after the allegation occurred.<br><br>On 1/4/21, at 3:48 p.m. during an interview the administrator stated sometime on 12/29/20, the LSW brought a concern forward for her to review. The administrator reviewed it and felt a VA report should be filed. The administrator confirmed the allegation of abuse was not reported timely to the SA within the two hour time frame and stated she expected all staff to report allegations of abuse timely.<br><br>Review of the facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities dated 11/17, identified verbal abuse as a form of maltreatment. The policy instructed staff to report suspected maltreatment to the SA immediately and no later than two hours after the allegation of maltreatment occurred if it involved | F 609 | | |

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| F 609 | Continued From page 6<br>abuse. | F 609 | | |