Electronically delivered
April 4, 2022

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

RE: CCN: 245489
Cycle Start Date: March 23, 2022

Dear Administrator:

On March 23, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 19, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 19, 2022.. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 19, 2022.
You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 19, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Emmanuel Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 19, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 23, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
April 4, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: CODV11

Dear Administrator:

The above facility was surveyed on March 22, 2022 through March 23, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 3/22/22 through 3/23/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H5489046C (MN81789). The following complaint was found to be SUBSTANTIATED: H5489045C (MN81668) with a licensing order issued at 0830. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct a thorough fall investigation and failed to ensure all staff implemented individualized fall interventions in	2 830	Corrected	4/24/22

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 accordance with the care plan in order to prevent and/or reduce the risk of falls for 1 of 3 residents (R1) who had a history of falls with injuries and major injury. This resulted in actual harm for R1, who required emergency transfer to the hospital for head laceration that required staples. Findings include: R1's quarterly Minimal Data Set (MDS) dated 2/15/22, indicated R1 had a diagnosis of dementia and had severe cognitive impairment. Further review of MDS indicated R1 did not ambulate, required extensive assist of two staff members for transfers, dressing and toileting. The MDS identified since the last assessment date of 11/17/21, R1 had two or more falls without injury, two or more falls with injury, and one fall with major injury. R1's physician orders dated 1/21/22, indicated ensure bed is level with wheelchair seat and wheelchair is locked and directed nursing staff to check to ensure six times a day for a fall intervention. R1's care plan revised 12/1/21, indicated R1 had an activities of daily living (ADLs) deficit related to impaired balance, history of falls, and terminal status and R1 required extensive assistance of one to two staff for transfers between surfaces. Further review of R1's care plan revised 1/25/22, indicated R1 was at high risk for falls related to history of falls, deconditioning, gait/balance problems, unaware of safety needs with self-transfers due to the progression of disease process. R1's fall interventions were as follows: -Ensure resident is wearing appropriate footwear during transfer, ambulation or mobilizing in wheelchair 7/28/21	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 -Place urinal at bedside table 8/7/21 -Offer to bring resident to the dining room for socialization 1 hour prior to meals 10/30/21 -Place resident's call light within reach and encourage to use it for assistance as needed. The resident needs prompt response to all requests for assistance 11/13/21 -Turn aides used when in bed 11/29/21 -Antilock brakes to wheelchair 1/10/22 -Bed to be at same level of his wheelchair seat and locked. 1/25/22 -Toileting program: bring resident to the toilet or offer him the urinal before meals daily. 3/8/22 Review of facility's Internal Investigation document dated 3/8/22, indicated R1 had an unwitnessed fall in his room on 3/8/22 at 11:45 a.m. The report indicated R1 had attempted self-transfer to the bathroom and was found "laying on his right side between recliner and nightstand. Laceration with bleeding noted to the back of resident's head, requiring higher level of care." Laceration to the back of the head measuring 4 centimeters long, which required 9 staples, and an abrasion to right side of forehead measuring 1.5 centimeters and required a bandage. Resident was transferred to the emergency room to treat wound. Review of Staff Written Statement dated 3/9/22, nursing assistant (NA)-A indicated she assisted R1 to lay in bed and placed the turn aids in bed beside resident. NA-A indicated about an hour later LPN-A alerted R1 had fallen. NA-A's statement did not identify other fall interventions if any were in place prior to exiting R1's room. On 3/22/23, at 11:19 a.m. NA-A indicated R1 required assistance by staff with ADLs such as toileting, dressing and transferring. NA-A	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 indicated R1 was able to make his needs known however, did not consistently use his call light and would self-transfer which put him at a high risk for falls. NA-A indicated on 3/8/22, she had assisted R1 with toileting and R1 requested to lay down which NA-A assisted him into bed. NA-A confirmed she was not aware of fall interventions for R1 at that time. NA-A indicated R1 had a fall previously and required his wheelchair to be placed next to his bed while he was in bed, however, NA-A was not aware of intervention and moved the wheelchair away from the bed and lowered R1's bed to the floor. NA-A was not sure how much time passed until licensed practical nurse (LPN)-A called for assistance and stated R1 had fallen. NA-A indicated when she entered R1's room after the fall, R1 was lying on the floor between his recliner and the nightstand. NA-A indicated R1 was showing some confusion talking about going to the kitchen, it appeared R1 had walked the length of his bed and his wheelchair was not near him. NA-A indicated R1 was transferred to the emergency room and returned to the facility with staples to his head. Further, NA-A indicated after the fall she was made aware she was supposed to place his wheelchair next to the bed. NA-A indicated fall interventions can be found in each resident's care plan however, NA-A confirmed she did not review his care plan prior to working with R1. In addition, NA-A confirmed she had not worked on the memory care unit for quite some time, and she was expected to read the care plans and ask questions if needed. NA-A indicated she had not worked on the memory care unit since the fall, the facility has not provided any additional education, and did not interview her regarding the fall. On 3/22/23, at 2:34 p.m. licensed practical nurse (LPN)-A indicated R1 required assistance by staff	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 for ADLs such as dressing and transferring. LPN-A indicated R1 did not ambulate anymore, utilized his wheelchair and would self-propel using his feet. LPN-A indicated R1 had a history of self-transferring and was a high fall risk. LPN-A explained one intervention to prevent R1's falls and assisted with a safe self-transfers was placing R1's wheelchair next to his bed at bed level. On 3/8/22, LPN-A indicated she heard R1 calling for help and upon arrival found R1 laying on the floor with blood on the floor. LPN-A called for assistance and applied pressure to reduce the bleeding from R1's head. R1 indicated he was trying to get to the kitchen. R1's wheelchair was noted to be off to the side and not near R1. Further, LPN-A indicated R1 was transferred to the emergency room for medical treatment and returned to the facility with 9 staples to his head. On 3/22/23, at 3:04 p.m. NA-C was observed assisting R1 with toileting and then laying R1 down in bed. R1 stood up from wheelchair and pivoted with stand by assistance of NA-C onto his bed. NA-C assisted with placing R1's legs onto bed and covered R1 with his blankets. R1 insisted on keeping his tennis shoes on while in bed and NA-C placed a body pillow and call light on the left side of R1's bed. NA-C lowered the bed to wheelchair level and placed wheelchair next to the bed with brakes locked. NA-C then exited R1's room. On 3/22/23, at 3:22 p.m. NA-C indicated R1 had a history of self-transferring from bed to wheelchair and then to the bathroom. NA-C indicated R1 did not attempt to ambulate. Further, NA-C indicated R1 was a fall risk and keeping his wheelchair next to bed and bed at wheelchair level was an intervention to prevent falls if he were to attempt to self-transfer.	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 On 3/22/23, at 3:25 p.m. R1 continued to lay in bed with his wheelchair next to the bed. R1 stated he has had some falls but was unable to remember what he was doing, kept stating his legs don't work like they used to. R1 also continued to say he uses his wheelchair to get around now. On 3/22/23, at 3:37 p.m. NA-D indicated fall interventions are communicated through report and each resident's care plan. Further, NA-D indicated staff are expected to review each care plan if there have been changes or are not familiar with the residents. NA-D indicated R1 was at risk for falls due to self-transferring. NA-D indicated R1's care plan directed staff to place his wheelchair with brakes locked next to bed and bed at wheelchair level as an intervention to prevent falls. On 3/22/23, at 7:16 p.m. NA-E indicated R1 required assistance with cares and did not ambulate but would utilize a wheelchair for mobility. NA-E indicated R1 had a history of self-transferring to his wheelchair but had not attempted to walk. Further, NA-E indicated due to self-transferring R1 was at risk for falls and interventions included placing wheelchair next to R1's bed with the brakes locked and bed at wheelchair level. NA-E indicated on 3/8/22, NA-A was "floating" between the memory care unit and the long-term care unit. NA-E indicated NA-A assisted R1 with toileting and laid R1 in bed. NA-E indicated she then went to break and when she returned 30 minutes later, it was reported R1 had fallen. NA-E was unsure what the root cause of R1's fall was. In addition, NA-E indicated staff were expected to review each resident's care plan if there were changes and new interventions	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 were communicated through report as well. On 3/23/22, at 8:49 a.m. nurse manager (NM)-A indicated R1 required assist of one from staff for ADLs and no longer ambulated but utilized a wheelchair for mobility. NM-A indicated R1 would self-transfer and staff were expected to place wheelchair at the bed level due to previous falls when self-transferring to uneven surfaces. NM-A confirmed when R1 attempted to self-transfer he was not attempting to ambulate, and it was usually surface to surface. NM-A indicated on 3/8/22, LPN-A heard R1 calling for help and staff alerted NM-A. NM-A entered R1's room to find R1 on the floor, noted he had hit his head on the nightstand, and his head was actively bleeding. R1 was transferred to the emergency room and returned to the facility with 9 staples. When asked what the root cause of the fall was, NM-A indicated root cause was related to R1's incontinence and attempting to go to the restroom. When asked what interventions were in place at the time of the fall NM-A indicated NA-A reported all interventions were in place at the time of the fall. NM-A confirmed she did not verify specific interventions with NA-A when she was conducting the investigation and indicated she used a general question of, were all interventions in place?, to which NA-A responded "yes" however, NA-A was not aware of specific fall interventions for R1 at the time of the fall. NM-A indicated staff are expected to investigate all fall interventions that were in place at the time of the fall to determine the root cause however, confirmed she did not ask NA-A if the wheelchair was placed next to the bed as part of the investigation. In addition, NM-A indicated R1's wheelchair was in the middle of the room when she entered the room to assist LPN-A.	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 On 3/23/22, at 9:53 a.m. director of nursing (DON) indicated fall interventions are communicated with staff through report and each resident's care plan and staff who are not familiar with the residents are expected to review their care plan prior to working with that resident. DON indicated on 3/8/22, R1 self-transferred attempting to go to the bathroom resulting in a fall and R1 received a laceration to the back of his head which required a transfer to the emergency room and received staples. Further, DON indicated R1 had a history of self-transferring and was at risk for falls and an intervention included wheelchair locked next to bed. DON reviewed the facility's 5-day investigation to the SA and stated all the pieces of the care plan were being followed however "you were told otherwise". In addition, DON indicated she was unsure if the wheelchair was placed next to R1's bed per resident's care plan at the time of the fall but she could assume it was near him. On 3/23/22, at 11:12 a.m. RN-C indicated R1 had a history of self-transferring and R1's care plan directed staff to keep his wheelchair next to bed with the brakes locked and bed at the same height as the wheelchair so if R1 were to attempt to self-transfer he would be able to do it safely. Further, RN-C indicated R1 did not attempt to ambulate but would attempt to transfer into his wheelchair. In addition, RN-C indicated the staff on day shift are usually consistent however, the evening and overnight shift staff will float between the memory care and the long-term care unit. On 3/23/22, at 11:23 a.m. administrator indicated R1's care plan did not contain the intervention for the wheelchair to be placed next to the bed. When asked what the care plan stated the administrator indicated bed at same level of	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 wheelchair seat and locked but stated it does not indicate the wheelchair needs to be placed next to the bed. Administrator was unsure why the bed would need to be at the same level of the wheelchair if the wheelchair did not need to be next to the bed, however, did state this intervention was initiated following a fall due to R1 self-transferring. Administrator indicated placing the wheelchair next to R1's bed would not have prevented the fall and does not agree the care plan was not being followed at the time of the fall. In addition, administrator indicated she was not sure on exact number of staff that float between the memory care unit and the long-term care unit and what staff are expected to do when they are not familiar with each resident and their interventions. On 3/23/22, at 11:52 a.m. NM-A confirmed R1's intervention directing staff to keep R1's bed at same level of wheelchair seat implied staff to keep the wheelchair next to the resident's bed at wheelchair level in case of attempts to self-transfer. In addition, NM-A indicated there was not a protocol in place for staff, that float between units, to familiarize themselves with the resident's interventions other than reading each resident's care plan prior to working with the resident. The facility did not provide a policy specifically for Falls or a Fall Program. Facility policy Accidents and Incidents - Investigating and Reporting dated July 2017, included: All accidents or incidents involving residents, employees, visitors, etc., occurring on our premises shall be investigated and reported to the administrator. 1. The nurse Supervisor/charge nurse and/or	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 department director or supervision shall promptly initiate and document investigation of the accident or incident 2. The following data, as applicable shall be included on risk management documentation: c) Circumstances surrounding the accident or incident. e) The name(s) of witnesses and their accounts of the accident or incident. f) The injured person's account of the incident k) Any corrective action taken l) Follow-up information m) Pertinent data as necessary or required. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 3/22/22 through 3/23/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H5489046C (MN81789). The following complaint was found to be SUBSTANTIATED: H5489045C (MN81668) with a licensing order issued at 0830. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct a thorough fall investigation and failed to ensure all staff implemented individualized fall interventions in	2 830	Corrected	4/24/22

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 accordance with the care plan in order to prevent and/or reduce the risk of falls for 1 of 3 residents (R1) who had a history of falls with injuries and major injury. This resulted in actual harm for R1, who required emergency transfer to the hospital for head laceration that required staples. Findings include: R1's quarterly Minimal Data Set (MDS) dated 2/15/22, indicated R1 had a diagnosis of dementia and had severe cognitive impairment. Further review of MDS indicated R1 did not ambulate, required extensive assist of two staff members for transfers, dressing and toileting. The MDS identified since the last assessment date of 11/17/21, R1 had two or more falls without injury, two or more falls with injury, and one fall with major injury. R1's physician orders dated 1/21/22, indicated ensure bed is level with wheelchair seat and wheelchair is locked and directed nursing staff to check to ensure six times a day for a fall intervention. R1's care plan revised 12/1/21, indicated R1 had an activities of daily living (ADLs) deficit related to impaired balance, history of falls, and terminal status and R1 required extensive assistance of one to two staff for transfers between surfaces. Further review of R1's care plan revised 1/25/22, indicated R1 was at high risk for falls related to history of falls, deconditioning, gait/balance problems, unaware of safety needs with self-transfers due to the progression of disease process. R1's fall interventions were as follows: -Ensure resident is wearing appropriate footwear during transfer, ambulation or mobilizing in wheelchair 7/28/21	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 -Place urinal at bedside table 8/7/21 -Offer to bring resident to the dining room for socialization 1 hour prior to meals 10/30/21 -Place resident's call light within reach and encourage to use it for assistance as needed. The resident needs prompt response to all requests for assistance 11/13/21 -Turn aides used when in bed 11/29/21 -Antilock brakes to wheelchair 1/10/22 -Bed to be at same level of his wheelchair seat and locked. 1/25/22 -Toileting program: bring resident to the toilet or offer him the urinal before meals daily. 3/8/22 Review of facility's Internal Investigation document dated 3/8/22, indicated R1 had an unwitnessed fall in his room on 3/8/22 at 11:45 a.m. The report indicated R1 had attempted self-transfer to the bathroom and was found "laying on his right side between recliner and nightstand. Laceration with bleeding noted to the back of resident's head, requiring higher level of care." Laceration to the back of the head measuring 4 centimeters long, which required 9 staples, and an abrasion to right side of forehead measuring 1.5 centimeters and required a bandage. Resident was transferred to the emergency room to treat wound. Review of Staff Written Statement dated 3/9/22, nursing assistant (NA)-A indicated she assisted R1 to lay in bed and placed the turn aids in bed beside resident. NA-A indicated about an hour later LPN-A alerted R1 had fallen. NA-A's statement did not identify other fall interventions if any were in place prior to exiting R1's room. On 3/22/23, at 11:19 a.m. NA-A indicated R1 required assistance by staff with ADLs such as toileting, dressing and transferring. NA-A	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 indicated R1 was able to make his needs known however, did not consistently use his call light and would self-transfer which put him at a high risk for falls. NA-A indicated on 3/8/22, she had assisted R1 with toileting and R1 requested to lay down which NA-A assisted him into bed. NA-A confirmed she was not aware of fall interventions for R1 at that time. NA-A indicated R1 had a fall previously and required his wheelchair to be placed next to his bed while he was in bed, however, NA-A was not aware of intervention and moved the wheelchair away from the bed and lowered R1's bed to the floor. NA-A was not sure how much time passed until licensed practical nurse (LPN)-A called for assistance and stated R1 had fallen. NA-A indicated when she entered R1's room after the fall, R1 was lying on the floor between his recliner and the nightstand. NA-A indicated R1 was showing some confusion talking about going to the kitchen, it appeared R1 had walked the length of his bed and his wheelchair was not near him. NA-A indicated R1 was transferred to the emergency room and returned to the facility with staples to his head. Further, NA-A indicated after the fall she was made aware she was supposed to place his wheelchair next to the bed. NA-A indicated fall interventions can be found in each resident's care plan however, NA-A confirmed she did not review his care plan prior to working with R1. In addition, NA-A confirmed she had not worked on the memory care unit for quite some time, and she was expected to read the care plans and ask questions if needed. NA-A indicated she had not worked on the memory care unit since the fall, the facility has not provided any additional education, and did not interview her regarding the fall. On 3/22/23, at 2:34 p.m. licensed practical nurse (LPN)-A indicated R1 required assistance by staff	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 for ADLs such as dressing and transferring. LPN-A indicated R1 did not ambulate anymore, utilized his wheelchair and would self-propel using his feet. LPN-A indicated R1 had a history of self-transferring and was a high fall risk. LPN-A explained one intervention to prevent R1's falls and assisted with a safe self-transfers was placing R1's wheelchair next to his bed at bed level. On 3/8/22, LPN-A indicated she heard R1 calling for help and upon arrival found R1 laying on the floor with blood on the floor. LPN-A called for assistance and applied pressure to reduce the bleeding from R1's head. R1 indicated he was trying to get to the kitchen. R1's wheelchair was noted to be off to the side and not near R1. Further, LPN-A indicated R1 was transferred to the emergency room for medical treatment and returned to the facility with 9 staples to his head. On 3/22/23, at 3:04 p.m. NA-C was observed assisting R1 with toileting and then laying R1 down in bed. R1 stood up from wheelchair and pivoted with stand by assistance of NA-C onto his bed. NA-C assisted with placing R1's legs onto bed and covered R1 with his blankets. R1 insisted on keeping his tennis shoes on while in bed and NA-C placed a body pillow and call light on the left side of R1's bed. NA-C lowered the bed to wheelchair level and placed wheelchair next to the bed with brakes locked. NA-C then exited R1's room. On 3/22/23, at 3:22 p.m. NA-C indicated R1 had a history of self-transferring from bed to wheelchair and then to the bathroom. NA-C indicated R1 did not attempt to ambulate. Further, NA-C indicated R1 was a fall risk and keeping his wheelchair next to bed and bed at wheelchair level was an intervention to prevent falls if he were to attempt to self-transfer.	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 On 3/22/23, at 3:25 p.m. R1 continued to lay in bed with his wheelchair next to the bed. R1 stated he has had some falls but was unable to remember what he was doing, kept stating his legs don't work like they used to. R1 also continued to say he uses his wheelchair to get around now. On 3/22/23, at 3:37 p.m. NA-D indicated fall interventions are communicated through report and each resident's care plan. Further, NA-D indicated staff are expected to review each care plan if there have been changes or are not familiar with the residents. NA-D indicated R1 was at risk for falls due to self-transferring. NA-D indicated R1's care plan directed staff to place his wheelchair with brakes locked next to bed and bed at wheelchair level as an intervention to prevent falls. On 3/22/23, at 7:16 p.m. NA-E indicated R1 required assistance with cares and did not ambulate but would utilize a wheelchair for mobility. NA-E indicated R1 had a history of self-transferring to his wheelchair but had not attempted to walk. Further, NA-E indicated due to self-transferring R1 was at risk for falls and interventions included placing wheelchair next to R1's bed with the brakes locked and bed at wheelchair level. NA-E indicated on 3/8/22, NA-A was "floating" between the memory care unit and the long-term care unit. NA-E indicated NA-A assisted R1 with toileting and laid R1 in bed. NA-E indicated she then went to break and when she returned 30 minutes later, it was reported R1 had fallen. NA-E was unsure what the root cause of R1's fall was. In addition, NA-E indicated staff were expected to review each resident's care plan if there were changes and new interventions	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 were communicated through report as well. On 3/23/22, at 8:49 a.m. nurse manager (NM)-A indicated R1 required assist of one from staff for ADLs and no longer ambulated but utilized a wheelchair for mobility. NM-A indicated R1 would self-transfer and staff were expected to place wheelchair at the bed level due to previous falls when self-transferring to uneven surfaces. NM-A confirmed when R1 attempted to self-transfer he was not attempting to ambulate, and it was usually surface to surface. NM-A indicated on 3/8/22, LPN-A heard R1 calling for help and staff alerted NM-A. NM-A entered R1's room to find R1 on the floor, noted he had hit his head on the nightstand, and his head was actively bleeding. R1 was transferred to the emergency room and returned to the facility with 9 staples. When asked what the root cause of the fall was, NM-A indicated root cause was related to R1's incontinence and attempting to go to the restroom. When asked what interventions were in place at the time of the fall NM-A indicated NA-A reported all interventions were in place at the time of the fall. NM-A confirmed she did not verify specific interventions with NA-A when she was conducting the investigation and indicated she used a general question of, were all interventions in place?, to which NA-A responded "yes" however, NA-A was not aware of specific fall interventions for R1 at the time of the fall. NM-A indicated staff are expected to investigate all fall interventions that were in place at the time of the fall to determine the root cause however, confirmed she did not ask NA-A if the wheelchair was placed next to the bed as part of the investigation. In addition, NM-A indicated R1's wheelchair was in the middle of the room when she entered the room to assist LPN-A.	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 On 3/23/22, at 9:53 a.m. director of nursing (DON) indicated fall interventions are communicated with staff through report and each resident's care plan and staff who are not familiar with the residents are expected to review their care plan prior to working with that resident. DON indicated on 3/8/22, R1 self-transferred attempting to go to the bathroom resulting in a fall and R1 received a laceration to the back of his head which required a transfer to the emergency room and received staples. Further, DON indicated R1 had a history of self-transferring and was at risk for falls and an intervention included wheelchair locked next to bed. DON reviewed the facility's 5-day investigation to the SA and stated all the pieces of the care plan were being followed however "you were told otherwise". In addition, DON indicated she was unsure if the wheelchair was placed next to R1's bed per resident's care plan at the time of the fall but she could assume it was near him. On 3/23/22, at 11:12 a.m. RN-C indicated R1 had a history of self-transferring and R1's care plan directed staff to keep his wheelchair next to bed with the brakes locked and bed at the same height as the wheelchair so if R1 were to attempt to self-transfer he would be able to do it safely. Further, RN-C indicated R1 did not attempt to ambulate but would attempt to transfer into his wheelchair. In addition, RN-C indicated the staff on day shift are usually consistent however, the evening and overnight shift staff will float between the memory care and the long-term care unit. On 3/23/22, at 11:23 a.m. administrator indicated R1's care plan did not contain the intervention for the wheelchair to be placed next to the bed. When asked what the care plan stated the administrator indicated bed at same level of	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 wheelchair seat and locked but stated it does not indicate the wheelchair needs to be placed next to the bed. Administrator was unsure why the bed would need to be at the same level of the wheelchair if the wheelchair did not need to be next to the bed, however, did state this intervention was initiated following a fall due to R1 self-transferring. Administrator indicated placing the wheelchair next to R1's bed would not have prevented the fall and does not agree the care plan was not being followed at the time of the fall. In addition, administrator indicated she was not sure on exact number of staff that float between the memory care unit and the long-term care unit and what staff are expected to do when they are not familiar with each resident and their interventions. On 3/23/22, at 11:52 a.m. NM-A confirmed R1's intervention directing staff to keep R1's bed at same level of wheelchair seat implied staff to keep the wheelchair next to the resident's bed at wheelchair level in case of attempts to self-transfer. In addition, NM-A indicated there was not a protocol in place for staff, that float between units, to familiarize themselves with the resident's interventions other than reading each resident's care plan prior to working with the resident. The facility did not provide a policy specifically for Falls or a Fall Program. Facility policy Accidents and Incidents - Investigating and Reporting dated July 2017, included: All accidents or incidents involving residents, employees, visitors, etc., occurring on our premises shall be investigated and reported to the administrator. 1. The nurse Supervisor/charge nurse and/or	2 830		

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 03/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 department director or supervision shall promptly initiate and document investigation of the accident or incident 2. The following data, as applicable shall be included on risk management documentation: c) Circumstances surrounding the accident or incident. e) The name(s) of witnesses and their accounts of the accident or incident. f) The injured person's account of the incident k) Any corrective action taken l) Follow-up information m) Pertinent data as necessary or required. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		