Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 17, 2023

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

RE: CCN: 245489
Cycle Start Date: February 1, 2023

Dear Administrator:

On February 15, 2023, we notified you a remedy was imposed. On March 7, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 28, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 15, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 28, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 17, 2023

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

Re: Reinspection Results
Event ID: YFU512

Dear Administrator:

On March 7, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 1, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2023

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

RE: CCN: 245489
Cycle Start Date: February 1, 2023

Dear Administrator:

On February 1, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 March 2, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 2, 2023.

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 March 2, 2023, 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 March 2, 2023. 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 August 1, 2023 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: YFU511

Dear Administrator:

The above facility was surveyed on January 31, 2023 through February 1, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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 feel free to call me with any questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	C 02/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/31/23 through 2/1/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54898072C (MN90419) with a deficiency cited at F689. The following complaint was found to be UNSUBSTANTIATED: H54897854C (MN90497), H54898040C (MN89779), H54895378C (MN87903), H54898041C (MN86930), H54898042C (MN86036). As a result of the investigation, an additional deficiency was cited at F603. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1)	F 603		2/28/23

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

Electronically Signed | 02/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 603	Continued From page 1 §483.12 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supporting clinical justification to ensure the least restrictive environment prior to placement of 1 of 1 residents (R1) in a secured unit. Findings include: R1's annual Minimal Data Set (MDS) dated 12/6/22, identified R1 had a diagnosis of traumatic brain injury and had moderately impaired cognition. R1 required staff assistance with activities of daily living (ADLs) such as transfers and locomotion on and off unit. R1 did not exhibit any behaviors. R1's Order Summary printed 2/2/23, lacked evidence R3 required a secured unit. R1's Elopement Risk Assessment dated 12/6/22, identified R1 had no history of elopement attempts and was determined to be at low risk for wandering.	F 603	Tag: F603 Corrective Action to resident to be affected: (R1) was made aware that this is a secure unit and informed of how to leave the unit if he wishes to do so. The unit has been changed to a long-term care unit and doors will no longer be locked. How The facility Identified other residents' potential to be affected: Area is no longer locked; therefore, no other residents are affected. Measures put in place to ensure it will not recur: Doors are no longer locked. Education provided to team members. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3	

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F 603	Continued From page 2 R1's undated room change document identified effective 8/24/22, R1 would be moving from room 136 to room 9 due to staffing changes. The document lacked a signature but stated verbal consent was given by R1's health care agent via telephone. In addition, the document lacked any information related to transitioning to a secured memory care unit. During an interview on 2/1/23, at 8:48 family member (FM)-B was unsure why R1 would require the need to live in a locked memory care unit as he had no history of elopement attempts, wandering behaviors, or severe cognitive impairment and stated R1 "does not belong in there". In addition, FM-B stated the facility did not offer any other placement within the facility, other than the memory care unit, when R3's previous unit closed. During an interview on 2/1/23, at 12:14 p.m. licensed practical nurse (LPN)-C indicated R1 did not exhibit wandering or exit seeking behaviors and did not have a history of elopement attempts. Further, LPN-C indicated one of the units in the facility closed and some residents who were not appropriate for a memory care unit ended up being moved to the secured unit, which LPN-C stated R1 was one of them. During an interview on 2/1/23, at 12:34 p.m. nursing assistant (NA)-B indicated R1 did not exhibit wandering or exit seeking behaviors and did not have a history of elopement attempts. Further, NA-B stated R1 was moved to the memory care unit when his previous unit closed. During an interview on 2/1/23, at 1:35 p.m.	F 603	months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Social services, Nurse managers, Director of Nursing or designee(s). Date of Completion: 2-28-23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 603	Continued From page 3 registered nurse (RN)- B indicated R1 transitioned to the memory care unit due R3's previous unit closing but R1 does not attempt to elope, or exit seek. Further, NA-B the facility process for admitting a resident living in the locked memory care unit did not include involvement from the resident's physician. RN-B indicated there were residents currently residing on the secured memory care unit who were cognitively intact due to a previous unit closing; however, each resident and their families were notified the resident would be moving to a secured unit. RN-B confirmed R1 did not know the code to go on and/or off the secured unit. During an interview on 2/1/23, at 2:38 p.m. RN-C indicated R1 had intact cognition with minimal confusion and did not exhibit any behaviors or elopement attempts. R1 transitioned to the facility's secured memory care unit when the facility closed another unit and the facility determined R1 to be appropriate for the secured unit due to impaired speaking and difficulty understanding R1 and the transition was not due to R1 requiring the need for a secured memory care unit. R1 did not know the code to go on and/or off the secured unit but would be able to leave the unit if a staff member was notified to unlock the door. The facility process for admitting a resident onto the secured memory care unit did not include the involvement of the resident's physician, but the decision was determined by the interdisciplinary team (IDT) and discussion with the resident's family. During an interview on 2/1/23, at 4:08 p.m. director of nursing (DON) identified the facility process for determining appropriateness to admit or transition a resident onto the memory care unit	F 603		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 603	Continued From page 4 would be discussed with the IDT and dependable on availability of rooms within the whole facility. DON stated there were seven residents who transitioned to the memory care unit when the facility closed a long term care unit which included some residents who volunteered, some with memory impairment and others who would benefit from a memory care unit. Further, DON stated R1 was on a secured unit and would be able to get on and/or off the unit independently because the code to the unit was posted at the door, which would be accessible to all residents currently residing on the secured unit. During an observation on 2/1/23, at 4:37 p.m. with DON walked onto the secured memory care unit and DON confirmed there was not a code posted next to the door to exit the unit. On 2/1/23, at 5:00 p.m. R1 was observed laying in bed. R1 stated he was not aware he was on a secured unit. R1 stated depending on the weather he would like to be able to leave the unit and go outside stated he was aware he had to notify staff if he was leaving the facility but did not know a code was needed to go on and/or off the unit. On 2/1/23, at 2:32 p.m. policy related to criteria for admitting residents to memory care unit was requested, but facility stated there was no policy.	F 603		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		2/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 689	Continued From page 5 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure residents were assessed to safely operate or provide necessary supervision to keep residents safe while utilizing an electric recliner for 2 of 6 residents (R3, R6) reviewed, who utilized an electric recliner. This resulted in actual harm when R3 lifted self in electric recliner using the remote causing a fall which resulted in a fracture. Findings include: R3's quarterly Minumum Data Set (MDS) dated 10/27/22, included a diagnosis of Parkinson's disease and had severely impaired cognition. R3 required extensive assistance by staff with transfers and ambulation. R3 had three falls since previous assessment 8/02/22, two of which resulted in injuries. R3's care plan dated 1/27/22, identified R3 was at risk for falls related to confusion, deconditioning, gait and balance deficits, and unaware of safety needs. On 6/12/22, R3's care plan was revised and directed staff not to leave R3 unsupervised in his room unless in bed. On 1/22/23, R3's care plan was revised and directed staff not to place R3 in the recliner in the commons area and to utilize a wheelchair. Incident report number 2026 dated 1/19/23, indicated at 4:30 p.m. R3 was observed sitting in recliner in lounge next to the nurses' station. R3	F 689	Tag: F 689 Corrective action to resident found to be affected: Electric recliner chairs have been removed from common areas, (R3) was assessed for use of recliner chair. Power source disabled from personal recliner so it serves as a regular sitting chair. How the facility identified other residents' potential to be affected: Those with personal power recliners have been assessed to determine safety of using power recliner. Chairs have been disabled or removed if assessment shows they are unsafe. Measures put in place to ensure it will not recur: Education to team members that assessment needs to be done prior to placement or use of a power recliner. How the facility will monitor its performance to ensure solutions are sustained: Audits weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors/Director of	

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	245489	A. BUILDING _____ B. WING _____	C 02/01/2023

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F 689	Continued From page 6 raised the recliner up into a "high sitting position" by utilizing the remote. R3 attempted to stand independently which resulted in an unwitnessed fall. R3's progress notes revealed the following: -On 1/19/23, at 4:30 p.m. R3 was observed in the recliner at the nurses' station when R3 raised the recliner up into high sitting position and attempted to stand which resulted in a fall. R3 was assessed and noted to have injuries which included: bruising to forehead and eye, hip and back pain, skin scrape to left elbow 2 centimeters (cm) by 2 cm, and skin scrape to left lower knee. -On 1/20/23, R3 was noted to be restless and attempted to climb out of recliner using the remote to raise the chair. R3 was noted to show signs of pain. -On 1/21/23, R3 was noted to be yelling out in pain during morning cares. R3's family was visiting and opted to send to emergency room due to change in condition. -On 1/22/23, R3 was admitted to the hospital -On 1/27/23, R3 re-admitted to the facility with hospice services. R3 would require the use of a mechanical Hoyer lift with assistance of two staff members for transfers due to being non-weight bearing to left lower extremity. Review of R3's hospital History and Physical dated 1/23/23, indicated R3 sustained a non-displaced bimalleolar left ankle fracture likely during his recurrent falls. Further review of document indicated R3 had frequent falls at the nursing home and approximately 3 to 4 days ago he fell and had been showing signs of discomfort and pain when moving left lower extremity.	F 689	Nursing/Social Services or designee(s). Date of completion: 2-28-23	

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F 689	Continued From page 7 During observation on 1/31/23, at 3:20 p.m. R3 was resting in bed, which was in lowest position, in his room. R3 appeared comfortable. During an interview on 2/1/23, at 9:00 a.m. nursing assistant (NA)-A stated R3 required assistance from staff for activities of daily living (ADLs) such as transferring and ambulation. NA-A indicated R3's cognition was impaired and was at risk for falls. Further, NA-A stated R3 had a fall from the electric recliner and sustained an ankle fracture which was discovered in the hospital. NA-A stated R3 was unable to appropriately use the remote to control the electric recliner, so staff would often place the remote behind the recliner on the floor and out of R3's reach. In addition, NA-A stated on the memory care unit, there were three electric recliners next to the nursing station that any residents were able to utilize, and the recliners were always plugged in however, staff would "hide" the remotes to the recliners, so residents were unable to use the remotes independently. During an interview on 2/1/23, at 9:19 a.m. family member (FM)-A indicated R3 had impaired cognition and was transitioned to the facility's memory care unit. FM-A stated R3 had a fall from an electric recliner, which he was "not safe to be in" and R3 had used the recliner remote unsupervised to lift the chair, resulting in a fall and "huge decline" in R3's condition. FM-A brought R3 to the hospital a couple days later due to change in condition and that is when a fracture in R3's ankle was discovered. During an interview on 2/1/23, at 10:37 a.m. licensed practical nurse (LPN)-A stated R3 had impaired cognition and safety awareness which	F 689		

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F 689	Continued From page 8 caused R3 to be at a high risk for falls. LPN-A stated R3 had a fall from an electric recliner by the nursing station which resulted in an ankle fracture and staff were directed not to place R3 in the electric recliners after the incident occurred. Further, LPN-A was unaware if a safety assessment was completed prior to allowing cognitively impaired residents to utilize the electric recliners. During an interview on 2/1/23, at 11:10 a.m. registered nurse (RN)-A indicated R3's cognition and safety awareness was impaired. RN-A indicated R3 had a history of self-transferring and staff would attempt to keep R3 in the commons area in an electric recliner by the nurses' station to keep him within staff's vision. Further, RN-A stated if R3 was sitting in an electric recliner staff would place the remote where R3 was not able to visually see it or reach it. RN-A indicated R3 would often search for the remote and if R3 was able to find it he would not appropriately use the remote and press the buttons causing the recliner to lift high and R3 would begin to slide out. In addition, RN-A was not aware of a safety assessment that would be completed prior to allowing cognitively impaired or otherwise identified unsafe residents to utilize the electric recliners. During an interview on 2/1/23, at 11:56 a.m. LPN-B indicated R3 had impaired cognition and was often restless, so staff would keep R3 in the commons area by the nurses' station to have him within vision due to being a high fall risk. LPN-B stated R3 had a recent fall from the electric recliner in the commons area next to the nurses' station when a nurse on duty left the area and R3 pressed the buttons on the remote which brought	F 689		

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F 689	Continued From page 9 the recliner all the way up to a high position causing R3 to fall and sustained injuries. Further, LPN-B stated R3 was observed to mess with the remote to the electric recliners prior to the incident and added, R3 was not appropriate for the electric recliners due to safety concerns and impaired cognition. LPN-B stated after R3's fall from the recliner, R3 was hospitalized due to a change in condition and when he returned to the facility, then required the use of a Hoyer mechanical lift for transfers due to an ankle fracture. During an interview on 2/1/23, at 12:14 p.m. LPN-C stated R3 had impaired cognition, poor safety awareness and was at high risk for falls which meant he required close supervision by staff. LPN-C stated they were to ensure R3 was not left in his room alone unless in bed and directed to place R3 in the electric recliners at the nurses' station to have good visual watch of him. Further, LPN-C confirmed R3 could not appropriately and safely operate the remote for the electric recliners. LPN-C indicated there were three electric recliners, which were always plugged in, by the nurses' station that any residents in the memory care unit could utilize, however LPN-C stated if the residents were at high risk for falls the staff would "hide" the remotes to the electric chair due to some residents' being observed to press the buttons inappropriately. During an interview on 2/1/23, at 12:34 p.m. NA-B indicated R3 was noted to be very confused, restless, and at a high risk for falls. NA-B indicated staff would place R3 in an electric recliner in the commons area next to the nurses' station and staff would recline his chair back, put	F 689		

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F 689	Continued From page 10 his feet up, and then place the remote out of R3's reach. Further, NA-B stated if R3 did find the remote to the electric chair he would press the buttons inappropriately which was what caused R3's fall prior to being sent to the hospital. During an interview on 2/1/23, at 12:50 p.m. NA-C indicated R3 had poor safety awareness and was at risk for falls due to poor balance. NA-C indicated R3 required staff supervision due to falls, so staff would place R3 in the electric recliners at the nurses' station. Further, NA-C indicated any residents could utilize the electric recliners at the nurses' station and they were always plugged in, however staff would not place a resident in the recliner if the resident was known to self-transfer or operate the remote inappropriately. NA-C confirmed R3 was known to self-transfer and operate the buttons on the recliner inappropriately and staff would still place R3 in the electric recliner as it was safer for him to be out in the commons area by the nurses' station for increased supervision rather than in his room. During an interview on 2/1/23, at 1:02 p.m. LPN-D indicated R3 had poor short-term memory and safety awareness and would often self-transfer which indicated he was at a high risk for falls. LPN-D indicated as a fall intervention, R3 was not allowed to be in his room alone unless R3 was in bed, so staff were directed to keep R3 in either his wheelchair or the electric recliners at the nurses' station. Further, LPN-D confirmed R3 could not appropriately operate the buttons on the electric chair, but staff would keep the chair plugged in, recline R3 back and elevate feet then leave the remote either on the floor behind the chair or place the remote in the pocket on the	F 689		

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F 689	Continued From page 11 side of the recliner. LPN-D indicated on 1/19/23, at approximately 2:00 p.m. R3 was observed sitting in the electric recliner and appeared to be resting reclined and feet were elevated. LPN-D could not recall where the remote for the electric recliner was at that time but stated it was either in the pocket on the side of the chair or behind the recliner on the floor. LPN-D stated she was not R3's nurse that day but was the only staff in the area at that time. LPN-D stated she stepped away and when returning to the area heard what sounded like a resident falling and when LPN-D came around the corner R3 was observed to be laying on the floor next to the recliner, the recliner was raised up. LPN-D indicated at that time R3 was not able to clearly verbalize where he was having pain but did point to left pelvis area. During an interview on 2/1/23, at 1:35 p.m. RN-B indicated prior to R3 being admitted to the hospital he required assistance by staff for ADLs and was able to ambulate with staff to and from destinations utilizing a walker and gait belt. RN-B indicated R3 had impaired cognition and safety awareness and was also noted to be impulsive which put him at a high risk for falls. RN-B indicated R3 always required visual supervision by staff unless R3 was in bed sleeping, however RN-B confirmed visual supervision was not in R3's care plan but RN-B stated she would expect staff to have visual contact on R3. RN-B stated there are three electric recliners at the nurses' station, which are always plugged in, that staff would place R3 in and ensure the remote was out of R3's reach. RN-B confirmed a safety assessment was not completed to determine if a resident is safe to operate the remote appropriately prior to residents utilizing the electric recliners and RN-B was not aware of a	F 689		

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F 689	Continued From page 12 procedure to ensure residents can safely use the electric recliners. Further, RN-B stated on 1/19/23, R3 was observed to be laying on the floor next to the electric recliner at the nurses' station, the recliner was noted to be lifted enough for R3 to slide out. R3 was noted to have pain to his left side but was unable to communicate exactly where the pain was located. On 1/21/23, R3 transferred to the hospital related to change in mental status, and facility staff were made aware of R3's ankle fracture on 1/24/23, when reviewing R3's hospital paperwork. RN-B stated R3 re-admitted to the facility on 1/27/23, and began hospice services and would now require the use of a full body Hoyer lift due to being non-weight bearing on left leg. During an interview on 2/1/23, at 2:20 p.m. LPN-E indicated R3 had impaired cognition and safety awareness. LPN-E indicated R3 required staff supervision and would often sit in the electric recliners at the nurses' station. LPN-E confirmed R3 would not operate the remote appropriately and staff would hide the remote for R3's safety. During an interview on 2/1/23, at 4:08 p.m. director of nursing (DON) indicated R3 had severely impaired cognition and safety awareness prior to being admitted to the hospital. DON indicated R3 required increased monitoring by staff and would often sit in the electric recliner for comfort and staff would place the remote in the side pocket of the chair. DON indicated on 1/19/23, R3 was in the electric recliner and used the remote to lift the chair, and was found on the floor next to the recliner. DON stated R3 was complaining of back and hip pain at that time, but when hospitalized a couple days later x-rays revealed an ankle fracture from the fall on	F 689		

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F 689	Continued From page 13 1/19/23. In addition, DON confirmed safety assessments were not part of the facility's procedure to determine safety of cognitively impaired residents utilizing the electric recliners. DON also confirmed the facility did not address the safety concern of the electric recliners following R3's fall on 1/19/22, which resulted in a fracture but would have been important to ensure residents who are cognitively impaired are safe to utilize the electric recliners which could have potentially prevented R3's fall. DON indicated staff have now been directed to unplug all three electric recliners at the nurses' station until further notice. R6's significant change MDS dated 12/7/22, included a diagnosis of dementia and R6 had severely impaired cognition. R6 had one fall with no injury since previous MDS assessment. On 2/1/23, at 5:09 p.m. R6 was observed sitting in an upright position with feet flat on the floor in an electric recliner at the nurses' station, the remote was on the floor behind R6's recliner and a green light was noted to be on indicating the recliner was receiving power. LPN-F grabbed the remote from the floor and operated the buttons, and R6's chair began to recline, and feet began to elevate which revealed the electric recliner was plugged in. During an interview on 2/1/23, at approximately 5:09 p.m. LPN-F stated R6 had severely impaired cognition and safety awareness and R6 was not able to appropriately use the remote for the electric recliner appropriately. The facility policy Safety and Supervision of Residents dated 7/17, indicated facility's	F 689		

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F 689	Continued From page 14 individualized resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary team would analyze information obtained from assessments and observations to identify specific accident hazards or risks for individual residents. Further policy direct facility to implement target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.	F 689		

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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 1/31/23 through 2/1/23, 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		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54898072C (MN90419) with a licensing order issued at 0830. The following complaints were found to be UNSUBSTANTIATED: H54897854C (MN90497), H54898040C (MN89779), H54895378C (MN87903), H54898041C (MN86930), H54898042C (MN86036). 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	2 000		

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2 000	Continued From page 2 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. 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 interview, observation, and document review, the facility failed to ensure residents were assessed to safely operate or provide necessary	2 830	Corrected	2/28/23

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 supervision to keep residents safe while utilizing an electric recliner for 2 of 6 residents (R3, R6) reviewed, who utilized an electric recliner. This resulted in actual harm when R3 lifted self in electric recliner using the remote causing a fall which resulted in a fracture. Findings include: R3's quarterly Minumum Data Set (MDS) dated 10/27/22, included a diagnosis of Parkinson's disease and had severely impaired cognition. R3 required extensive assistance by staff with transfers and ambulation. R3 had three falls since previous assessment 8/02/22, two of which resulted in injuries. R3's care plan dated 1/27/22, identified R3 was at risk for falls related to confusion, deconditioning, gait and balance deficits, and unaware of safety needs. On 6/12/22, R3's care plan was revised and directed staff not to leave R3 unsupervised in his room unless in bed. On 1/22/23, R3's care plan was revised and directed staff not to place R3 in the recliner in the commons area and to utilize a wheelchair. Incident report number 2026 dated 1/19/23, indicated at 4:30 p.m. R3 was observed sitting in recliner in lounge next to the nurses' station. R3 raised the recliner up into a "high sitting position" by utilizing the remote. R3 attempted to stand independently which resulted in an unwitnessed fall. R3's progress notes revealed the following: -On 1/19/23, at 4:30 p.m. R3 was observed in the recliner at the nurses' station when R3 raised the recliner up into high sitting position and attempted	2 830		

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2 830	Continued From page 4 to stand which resulted in a fall. R3 was assessed and noted to have injuries which included: bruising to forehead and eye, hip and back pain, skin scrape to left elbow 2 centimeters (cm) by 2 cm, and skin scrape to left lower knee. -On 1/20/23, R3 was noted to be restless and attempted to climb out of recliner using the remote to raise the chair. R3 was noted to show signs of pain. -On 1/21/23, R3 was noted to be yelling out in pain during morning cares. R3's family was visiting and opted to send to emergency room due to change in condition. -On 1/22/23, R3 was admitted to the hospital -On 1/27/23, R3 re-admitted to the facility with hospice services. R3 would require the use of a mechanical Hoyer lift with assistance of two staff members for transfers due to being non-weight bearing to left lower extremity. Review of R3's hospital History and Physical dated 1/23/23, indicated R3 sustained a non-displaced bimalleolar left ankle fracture likely during his recurrent falls. Further review of document indicated R3 had frequent falls at the nursing home and approximately 3 to 4 days ago he fell and had been showing signs of discomfort and pain when moving left lower extremity. During observation on 1/31/23, at 3:20 p.m. R3 was resting in bed, which was in lowest position, in his room. R3 appeared comfortable. During an interview on 2/1/23, at 9:00 a.m. nursing assistant (NA)-A stated R3 required assistance from staff for activities of daily living (ADLs) such as transferring and ambulation. NA-A indicated R3's cognition was impaired and was at risk for falls. Further, NA-A stated R3 had a fall from the electric recliner and sustained an	2 830		

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2 830	Continued From page 5 ankle fracture which was discovered in the hospital. NA-A stated R3 was unable to appropriately use the remote to control the electric recliner, so staff would often place the remote behind the recliner on the floor and out of R3's reach. In addition, NA-A stated on the memory care unit, there were three electric recliners next to the nursing station that any residents were able to utilize, and the recliners were always plugged in however, staff would "hide" the remotes to the recliners, so residents were unable to use the remotes independently. During an interview on 2/1/23, at 9:19 a.m. family member (FM)-A indicated R3 had impaired cognition and was transitioned to the facility's memory care unit. FM-A stated R3 had a fall from an electric recliner, which he was "not safe to be in" and R3 had used the recliner remote unsupervised to lift the chair, resulting in a fall and "huge decline" in R3's condition. FM-A brought R3 to the hospital a couple days later due to change in condition and that is when a fracture in R3's ankle was discovered. During an interview on 2/1/23, at 10:37 a.m. licensed practical nurse (LPN)-A stated R3 had impaired cognition and safety awareness which caused R3 to be at a high risk for falls. LPN-A stated R3 had a fall from an electric recliner by the nursing station which resulted in an ankle fracture and staff were directed not to place R3 in the electric recliners after the incident occurred. Further, LPN-A was unaware if a safety assessment was completed prior to allowing cognitively impaired residents to utilize the electric recliners. During an interview on 2/1/23, at 11:10 a.m. registered nurse (RN)-A indicated R3's cognition	2 830		

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2 830	Continued From page 6 and safety awareness was impaired. RN-A indicated R3 had a history of self-transferring and staff would attempt to keep R3 in the commons area in an electric recliner by the nurses' station to keep him within staff's vision. Further, RN-A stated if R3 was sitting in an electric recliner staff would place the remote where R3 was not able to visually see it or reach it. RN-A indicated R3 would often search for the remote and if R3 was able to find it he would not appropriately use the remote and press the buttons causing the recliner to lift high and R3 would begin to slide out. In addition, RN-A was not aware of a safety assessment that would be completed prior to allowing cognitively impaired or otherwise identified unsafe residents to utilize the electric recliners. During an interview on 2/1/23, at 11:56 a.m. LPN-B indicated R3 had impaired cognition and was often restless, so staff would keep R3 in the commons area by the nurses' station to have him within vision due to being a high fall risk. LPN-B stated R3 had a recent fall from the electric recliner in the commons area next to the nurses' station when a nurse on duty left the area and R3 pressed the buttons on the remote which brought the recliner all the way up to a high position causing R3 to fall and sustained injuries. Further, LPN-B stated R3 was observed to mess with the remote to the electric recliners prior to the incident and added, R3 was not appropriate for the electric recliners due to safety concerns and impaired cognition. LPN-B stated after R3's fall from the recliner, R3 was hospitalized due to a change in condition and when he returned to the facility, then required the use of a Hoyer mechanical lift for transfers due to an ankle fracture.	2 830		

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2 830	Continued From page 7 During an interview on 2/1/23, at 12:14 p.m. LPN-C stated R3 had impaired cognition, poor safety awareness and was at high risk for falls which meant he required close supervision by staff. LPN-C stated they were to ensure R3 was not left in his room alone unless in bed and directed to place R3 in the electric recliners at the nurses' station to have good visual watch of him. Further, LPN-C confirmed R3 could not appropriately and safely operate the remote for the electric recliners. LPN-C indicated there were three electric recliners, which were always plugged in, by the nurses' station that any residents in the memory care unit could utilize, however LPN-C stated if the residents were at high risk for falls the staff would "hide" the remotes to the electric chair due to some residents' being observed to press the buttons inappropriately. During an interview on 2/1/23, at 12:34 p.m. NA-B indicated R3 was noted to be very confused, restless, and at a high risk for falls. NA-B indicated staff would place R3 in an electric recliner in the commons area next to the nurses' station and staff would recline his chair back, put his feet up, and then place the remote out of R3's reach. Further, NA-B stated if R3 did find the remote to the electric chair he would press the buttons inappropriately which was what caused R3's fall prior to being sent to the hospital. During an interview on 2/1/23, at 12:50 p.m. NA-C indicated R3 had poor safety awareness and was at risk for falls due to poor balance. NA-C indicated R3 required staff supervision due to falls, so staff would place R3 in the electric recliners at the nurses' station. Further, NA-C indicated any residents could utilize the electric recliners at the nurses' station and they were	2 830		

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2 830	Continued From page 8 always plugged in, however staff would not place a resident in the recliner if the resident was known to self-transfer or operate the remote inappropriately. NA-C confirmed R3 was known to self-transfer and operate the buttons on the recliner inappropriately and staff would still place R3 in the electric recliner as it was safer for him to be out in the commons area by the nurses' station for increased supervision rather than in his room. During an interview on 2/1/23, at 1:02 p.m. LPN-D indicated R3 had poor short-term memory and safety awareness and would often self-transfer which indicated he was at a high risk for falls. LPN-D indicated as a fall intervention, R3 was not allowed to be in his room alone unless R3 was in bed, so staff were directed to keep R3 in either his wheelchair or the electric recliners at the nurses' station. Further, LPN-D confirmed R3 could not appropriately operate the buttons on the electric chair, but staff would keep the chair plugged in, recline R3 back and elevate feet then leave the remote either on the floor behind the chair or place the remote in the pocket on the side of the recliner. LPN-D indicated on 1/19/23, at approximately 2:00 p.m. R3 was observed sitting in the electric recliner and appeared to be resting reclined and feet were elevated. LPN-D could not recall where the remote for the electric recliner was at that time but stated it was either in the pocket on the side of the chair or behind the recliner on the floor. LPN-D stated she was not R3's nurse that day but was the only staff in the area at that time. LPN-D stated she stepped away and when returning to the area heard what sounded like a resident falling and when LPN-D came around the corner R3 was observed to be laying on the floor next to the recliner, the recliner was raised up. LPN-D indicated at that time R3	2 830		

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2 830	Continued From page 9 was not able to clearly verbalize where he was having pain but did point to left pelvis area. During an interview on 2/1/23, at 1:35 p.m. RN-B indicated prior to R3 being admitted to the hospital he required assistance by staff for ADLs and was able to ambulate with staff to and from destinations utilizing a walker and gait belt. RN-B indicated R3 had impaired cognition and safety awareness and was also noted to be impulsive which put him at a high risk for falls. RN-B indicated R3 always required visual supervision by staff unless R3 was in bed sleeping, however RN-B confirmed visual supervision was not in R3's care plan but RN-B stated she would expect staff to have visual contact on R3. RN-B stated there are three electric recliners at the nurses' station, which are always plugged in, that staff would place R3 in and ensure the remote was out of R3's reach. RN-B confirmed a safety assessment was not completed to determine if a resident is safe to operate the remote appropriately prior to residents utilizing the electric recliners and RN-B was not aware of a procedure to ensure residents can safely use the electric recliners. Further, RN-B stated on 1/19/23, R3 was observed to be laying on the floor next to the electric recliner at the nurses' station, the recliner was noted to be lifted enough for R3 to slide out. R3 was noted to have pain to his left side but was unable to communicate exactly where the pain was located. On 1/21/23, R3 transferred to the hospital related to change in mental status, and facility staff were made aware of R3's ankle fracture on 1/24/23, when reviewing R3's hospital paperwork. RN-B stated R3 re-admitted to the facility on 1/27/23, and began hospice services and would now require the use of a full body Hoyer lift due to being non-weight bearing on left leg.	2 830		

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2 830	Continued From page 10 During an interview on 2/1/23, at 2:20 p.m. LPN-E indicated R3 had impaired cognition and safety awareness. LPN-E indicated R3 required staff supervision and would often sit in the electric recliners at the nurses' station. LPN-E confirmed R3 would not operate the remote appropriately and staff would hide the remote for R3's safety. During an interview on 2/1/23, at 4:08 p.m. director of nursing (DON) indicated R3 had severely impaired cognition and safety awareness prior to being admitted to the hospital. DON indicated R3 required increased monitoring by staff and would often sit in the electric recliner for comfort and staff would place the remote in the side pocket of the chair. DON indicated on 1/19/23, R3 was in the electric recliner and used the remote to lift the chair, and was found on the floor next to the recliner. DON stated R3 was complaining of back and hip pain at that time, but when hospitalized a couple days later x-rays revealed an ankle fracture from the fall on 1/19/23. In addition, DON confirmed safety assessments were not part of the facility's procedure to determine safety of cognitively impaired residents utilizing the electric recliners. DON also confirmed the facility did not address the safety concern of the electric recliners following R3's fall on 1/19/22, which resulted in a fracture but would have been important to ensure residents who are cognitively impaired are safe to utilize the electric recliners which could have potentially prevented R3's fall. DON indicated staff have now been directed to unplug all three electric recliners at the nurses' station until further notice. R6's significant change MDS dated 12/7/22, included a diagnosis of dementia and R6 had	2 830		

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2 830	Continued From page 11 severely impaired cognition. R6 had one fall with no injury since previous MDS assessment. On 2/1/23, at 5:09 p.m. R6 was observed sitting in an upright position with feet flat on the floor in an electric recliner at the nurses' station, the remote was on the floor behind R6's recliner and a green light was noted to be on indicating the recliner was receiving power. LPN-F grabbed the remote from the floor and operated the buttons, and R6's chair began to recline, and feet began to elevate which revealed the electric recliner was plugged in. During an interview on 2/1/23, at approximately 5:09 p.m. LPN-F stated R6 had severely impaired cognition and safety awareness and R6 was not able to appropriately use the remote for the electric recliner appropriately. The facility policy Safety and Supervision of Residents dated 7/17, indicated facility's individualized resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary team would analyze information obtained from assessments and observations to identify specific accident hazards or risks for individual residents. Further policy direct facility to implement target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) 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	2 830		

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2 830	Continued From page 12 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		