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	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Nursing Home	1415 Madison Avenue Detroit Lakes, MN 56501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 Based on observation, interview and document review, the facility failed to provide range of motion (ROM) (refers to how far you can move or stretch a part of your body) services to prevent a potential decrease in range of motion for 1 of 1 resident (R21) reviewed who required range of motion for restorative nursing exercises. Findings include: R21's annual Minimum Data Set (MDS) dated [DATE], indicated R21 was cognitively intact. R21 had a diagnoses which included hemiplegia (a condition caused by brain damage that leads to paralysis on one side of the body,) cerebral infarction affecting the left non-dominant side (stroke), heart failure, and hypertension (high blood pressure). R21 required extensive assistance with bed mobility, transfers, and toileting. R21's Significant Change Care Area Assessment (CAA) dated 10/30/24, indicated R21 was able to voice concerns and preferences and make daily choices. R21 required extensive assistance with activities of daily living (ADLs) which included dressing, bed mobility, and transfers. R21's current care plan revised 8/2/24, revealed restorative nursing program in place as directed, initiated on 3/3/3017, and revised on 8/2/24. ROM provided with morning (AM) afternoon (HS) cares (activities of daily living), Date initiated 3/11/24. During the review of Occupational Therapy (OT) evaluation and plan of treatment dated 2/27/24-5/26/24, revealed R21's musculoskeletal system assessment identified the right upper extremity range of motion was within normal limits. Left upper extremity was impaired. Lower right extremity was within normal limits. Left lower extremity was impaired. During the review of nursing assistant care sheets titled team two, dated 12/18/2024, indicated R21 was to receive range of motion with AM/HS cares. During an interview on 12/16/24 at 1:22 p.m., R21 indicated staff stopped the range of motion restorative program about two years ago. R21 indicated it would have been nice to have stretching, especially on his knee. R21 stated his knee had an increase in stiffness. R21 indicated he talked to staff about wanting to have stretching done however range of motion was not being completed daily. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 2:24 p.m., nursing assistant (NA)-C indicated R21 did not have a ROM program in place. NA-C stated R21 never had a ROM program. NA-C indicated she had received training on ROM and restorative programs in the past. During an interview on 12/17/24 at 2:38 p.m., NA-F indicated R21 did not have a restorative program or ROM with cares. During an interview on 12/17/24 at 3:56 p.m., the occupational therapy assistant indicated therapy recommended range of motion to be completed by nursing staff when R21 was getting dressed. It was not added for additional care however should have been incorporated with activities of daily living (ADLs). During an interview on 12/17/24 at 2:46 p.m., registered nurse (RN)-B indicated R21 had a ROM program in the morning and evening when getting dressed. RN-B indicated she had worked with R21 since he was admitted and R21 had always had a ROM program. During an interview on 12/17/24 at 2:58 p.m., clinical manager indicated R21 was cognitively intact however does have some recall issues such as what he ate for supper last night. The clinical manager indicated ROM was to be completed with morning and evening cares. The clinical manager revealed she was in charge of making sure ROM was completed. The clinical manager revealed in the past ROM was a task on the computer that staff would chart when it was finished. The task was removed to save time when charting. The clinical manager indicated ROM for R21 was care planned under ADLs and was care planned on 3/11/24. The clinical manager verified that R21 had a restorative ROM program. Clinical manager indicated nursing assistants should have been completing the ROM program with morning and evening cares. The clinical manager stated ROM was important due to stroke, and a potential for increase of contractions if the tasks were not completed. The clinical manager would expect staff to perform his ROM and report if he refused. During an interview on 12/17/24 at 3:37 p.m., registered nurse (RN)-A, was unsure if R21 had a ROM program. During an interview on 12/18/24 at 7:10 a.m., NA-H indicated she was not aware if R21 had a restorative program. During an interview on 12/18/24 at 8:44 a.m., licsensed practical nurse (LPN)-C was unsure if R21 had a ROM program. During an interview on 12/18/24 at 8:50 a.m., NA-B indicated she was trained in ROM and restorative programs. NA-B indicated all residents were supposed to have ROM exercise completed. NA-B indicated she had worked as a restorative aid and completed ROM on all residents. NA-B reported she no longer worked as a restorative aid as that program was stopped and now all nursing assistants were expected to perform ROM. During an interview on 12/18/24 at 8:57 a.m., physical therapist looked at R21's care plan on the computer and verified that R21 had a ROM program. Upper extremities stretching for five seconds counts in the morning, and the afternoon shift to do ROM on the lower extremities. The Physical Therapist indicated ROM was important for R21, especially for his left arm. The physical therapist would expect staff to perform ROM at least in the morning. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 12/18/24 9:03 a.m., the Rehab and therapy director (RTD) indicated that if there was a change in R21's condition, therapy would do an evaluation. Nurses were expected to communicate with the therapy department if there was an issue, such as residents becoming more stiff or declining in function. Based on the evaluation, R21 would start therapy, or have nursing continue with the ROM program. If the ROM was not getting done, nursing staff were expected to communicate that with the therapy department. The RTD reported the therapy department did not have time to follow ROM programs. The RTD indicated therapy would have to completed an assessment while R21 was in bed to see if there had been a change with R21's ROM. RTD stated ROM was important to maintain a residents ability to sit or stand and have less muscle contractors. RTD indicated staff completing ROM on R21 would assist in maintaining R21's joint integrity. During an interview on 12/18/24 at 9:20 a.m., director of nursing (DON) indicated when a resident was discharged from therapy, ROM was added to the care plan for the nursing staff to complete. DON reported that R21 did have ROM in the care plan. DON expected staff to follow the care plan. DON stated ROM was important to prevent a decline and contractures. DON stated if a resident refused ROM it should have been documented and reported. During a follow-up interview and observation on 12/18/24 at 11:04 a.m., RTD entered R21's room to assess R21's ROM. R21 was lying down in bed and stated his knee had become more stiff, however denied pain. RTD performed ROM and completed an assessment. The RTD stated there was no decrease in ROM and no change in ROM. RTD recommended that staff would complete ROM daily. A policy titled Restorative Nursing Services dated 2001 revealed Residents would receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consisted of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational, or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative cares. Restorative goals and objectives were individualized and resident-centered, and were outlined in the resident's plan of care. A policy titled Resident Mobility and Range of Motion dated 2001 revealed residents would not experience an avoidable reduction in range of motion (ROM). Residents with limited range of motion would receive treatment and services to increase and/or prevent a further decrease in ROM. Documentation of resident's progress toward the goals and objectives would include attempts to address any changes or decline in the resident's condition or needs. .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to accurately assess and implement safe smoking interventions for 1 of 1 resident (R6) reviewed for smoking. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6 had diagnoses which included diabetes mellitus (DM), anemia (a condition where there are lower than normal number of red blood cells in the body), and hypertension (elevated blood pressure). Identified R6 had intact cognition and required extensive assistance from staff with activities of daily living (ADL's) which included transfers and toileting. R6's significant change in status Care Area assessment dated [DATE], identified interventions were in place to address safety needs. R6's care plan dated 4/11/24, identified the facility had determined R6 was safe to smoke independently. Care plan identified a goal that R6 refrained from smoking in inappropriate places. R6's smoking assessment dated [DATE], indicated R6 was safe to light the cigarette, extinguish and dispose of cigarette safely. Assessment indicated R had not required a smoking apron and was safe to smoke without supervision. Assessment lacked information regarding burns on R6's clothing R6's smoking assessment dated [DATE], indicated R6 was safe to light the cigarette, extinguish and dispose of cigarette safely. Indicated R6 was to bring the cigarette butt to disposal at front entrance of the facility. Assessment further indicated R had not required a smoking apron and was safe to smoke without supervision. Assessment lacked information regarding burns on R6's clothing. Review of R6's clothing log titled closet items with burn holes in them dated 10/25/24 identified one blue and gray shirt, black jacket with 16 holes, flannel shirt, black ling sleeve shirt, three tank tops, see through black and white shirt, and a 3/4 sleeve shirt. During an interview on 12/16/24 at 12:55 p.m., R6 stated she was a smoker and the facility stored her cigarettes and lighter for her. R6 stated she did not need a smoking apron and was able to go outside by herself off the facility grounds to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/16/24 at 1:05 p.m., R6 was seated in her electric scooter at the nurses station wearing a black winter jacket which contained several burn holes in the front of the jacket. R6 stated the holes were from smoking however the jacket was an old jacket from prior to her admission to the facility. R6 received a case with hand rolled cigarettes and a lighter from licensed practical nurse (LPN)-A. R6 proceeded outside and down the hill in her electric scooter. R6 proceeded approximately one block down the road before stopping on the street near an apartment building. R6 removed a rolled cigarette from the case and used the lighter to light the cigarette. As R6 began smoking the cigarette ashes began falling onto her pants. R6 had not made any effort to remove the cigarette ashes from her pants and continued smoking. R6 used her index finger on her left hand to flip the cherry off of the cigarette onto the ground and placed the paper from the cigarette into the case with the other cigarettes. R6 then removed another cigarette from the case and lit the cigarette with the lighter. As R6 began smoking the cigarette ashes fell on to her pants. R6 made no effort to remove the ashes from her pants and continued smoking. R6 used her index finger on her left hand to flip the cherry off of the cigarette onto the ground and held the paper from the cigarette in her left hand. R6 proceeded back up the hill in her electric scooter and placed both the paper in her hand and the one she had placed in the case into the cigarette receptacle which was located approximately 200 feet from the front entrance of the building. During an observation on 12/17/24 at 8:35 a.m., nurse manager (NM)-A was standing outside at the top of the hill next to a cigarette receptacle while R6 was smoking a cigarette. During an interview on 12/17/24 at 9:08 a.m., laundry supervisor (LS) stated she had noticed several burn holes in R6's black winter jacket about two weeks ago when she washed the jacket. LS indicated she had not seen burns in any of R6's other clothing that had come down to be washed. During an interview on 12/17/24 at 11:00 a.m., nursing assistant (NA)-A stated R6 was a smoker and the nurses stored R6's cigarettes for her. NA-A stated R6 was able to smoke without supervision or a smoking apron. NA-A stated she had noticed at least one burn hole in R6's black winter jacket about a month or so ago. During an interview on 12/17/24 at 9:44 a.m., NA-B stated R6 was a smoker and the nurses stored R6's cigarettes for her. NA-A stated R6 was able to smoke without supervision or a smoking apron. NA-A stated she had noticed several burn holes in R6's black winter jacket about a month ago. During an interview on 12/17/24 at 11:02 a.m., LPN-B stated R6 was a smoker and the nurses stored R6's cigarettes for her. LPN-B stated R6 was able to smoke without supervision or a smoking apron. LPN-B stated she had noticed several burn holes in R6's black winter jacket about a month ago. During an observation on 12/17/24 at 12:35 p.m., R6 was sitting in her electric scooter at the nurses station wearing a black jacket with contained several burn holes. R6 received a pack of cigarettes which contained hand rolled cigarettes and a lighter from LPN-A. R6 proceeded outside in her electric scooter to the top of the hill near the cigarette receptacle. As R6 lit her cigarette several ashes fell on to her jacket. R6 made no attempt to remove the ashes and continued smoking. R6 extinguished the cigarette out on the side of the cigarette receptacle and placed the paper from the cigarette into the receptacle and proceeded back into the building in her electric scooter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 3:16 p.m., clinical manager (CM)-A stated she had become aware of the holes in R6's jacket and clothes when she did R6's smoking assessment on 10/25/24. CM-A stated R6 had told her the holes in her clothes and jacket happened prior to her admission to the facility. CM-A stated she had not considered having R6 use a smoking apron and now feels it may be a good idea because of the history of R6 burning her clothing while smoking. CM-A stated the facility had ordered R6 a smoking apron. CM-A indicated she had moved the cigarette receptacle and smoking area so that it was closer for R6 and so she would be able to safely extinguish her cigarettes. During an interview on 12/17/24 at 3:38 p.m., director of nursing (DO) stated she had been aware of the holes in R6's jacket and clothing since 10/25/24. DON stated the cigarette receptacle was moved closer for R6 so she was able to safely extinguish her cigarettes and a smoking apron was ordered for R6 to ensure her safety while smoking. DON stated her expectation was that R6 was safe while smoking. A facility policy titled Smoking Policy-Residents revised 8/22, identified smoking was only permitted in designated resident smoking areas. Identified metal containers, with self-closing cover devices, are available in smoking areas. Identified an assessment to determine the ability to smoke was done for any resident who desired to smoke.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 4 residents (R34) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to implement hand hygiene for 3 of 3 residents (R3, R4, R5) observed during medication administration. Findings include: PPE Review of CDC guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R34's quarterly Minimum Data Set (MDS) dated [DATE], identified R34 had moderate cognitive impairment and diagnoses which included hypertension (elevated blood pressure), anxiety, and depression. Identified R34 required extensive assist with activities of daily living (ADL's) which included toileting, transfer, and dressing R34's care plan revised 12/9/24, indicated R34 had a catheter related to urinary retention. Care plan directed staff to monitor for any urinary tract infection (UTI) symptoms and report to medical doctor (MD). During an observation on 12/16/24 at 2:34 p.m., there was no PPE located near R34's room for staff to wear while providing care for R34 (who was on EBP). Further, there was no sign to identify R34 was on EBP. During an observation on 12/16/24 at 5:19 p.m., nursing assistant (NA)-C and NA-D entered R34's room, sanitized hands and applied gloves. NA-C and NA-D rolled R34 to her side and checked her brief which was dry and proceeded to place a hoyer sheet under R34 while standing within an inch of R34. NA-C and NA-D hooked R34 up to the hoyer using the lift sheet and placed R34 into her wheelchair. NA-C and NA-D were standing within an inch of R34 during the hoyer lift transfer. The only PPE NA-C and NA-D were wearing was gloves. During a joint interview on 12/16/24 at 5:39 p.m., NA-C and NA-D verified they had only worn gloves when transferring R34 into her wheelchair. NA-C and NA-D stated they understood that gloves were the only PPE required to care for R34. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/18/24 at 9:05 a.m., there was a plastic container with three drawers which contained gowns, gloves, masks, sitting on the floor next to R34's doorway. Additionally there was a sign on R34's room door that said Enhanced Barrier Precautions; Everyone Must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer gown, and gloves. During an observation on 12/18/24 at 9:05 a.m., NA-B entered R34's room wearing no PPE and removed a wash basin for from R43's closet, went to the bathroom, filled the basin with water and placed three washcloths into the basin. NA-B went back to R34's closet, brought out a pair of pants and brought them to R34's bedside. NA-B walked up to R34 who was lying in bed and told her she was going to assist her with getting washed up and dressed. NA-B sanitized hands and applied gloves. NA-B proceeded to take a washcloth and wipe R34's armpits, rinsed and dried R34's armpits. NA-B applied new gloves and took a clean washcloth from the basin and cleaned R34's perineal area from front to back then used another washcloth to rinse R34's perineal area. NA-B removed gloves and placed a clean brief on R34. NA-B the proceeded to place R34's pants on her and roll R34 to her right side and pulled up the pants. At no time during the observation did NA-B wear a gown. During an interview on 12/18/24 at 9:35 a.m., NA-B verified the only PPE she had used while caring for R34 was gloves. NA-B stated she had forgotten what EBP was however stated she probably should have been wearing a gown while caring for R34. HAND HYGIENE During a continuous observation on 12/16/24 at 7:05 p.m., LPN-D applied gloves and used a lancet (a device to poke a finger in order to get blood) to obtain blood to test R5's blood sugar. A small drop of blood landed on LPN-D's gloved finger on her right hand. LPN-D removed gloves and applied clean gloves and administered eye drops to each of R5's eyes. LPN-D removed gloves and placed R5's glucometer in the cupboard in R5's room. LPN-D walked to the med cart, removed medication for R4 and administered oral medications to R4. LPN-D proceeded to the med cart, touched the computer screen to sign out R4's medications, pulled out the narcotic book and signed out a narcotic for R3. LPN -D removed the narcotic from the med cart after touching several other cartridges in the narcotic drawer. LPN-D administered the narcotic to R3. At no time during the above observation did LPN-D perform hand hygiene. During an interview on 12/16/24 at 7:40 LPN-D verified she had not performed hand hygiene during the above observation. LPN-D stated she should have performed hand hygiene after removing the soiled gloves and before passing medications to each resident. During an interview on 12/18/24 at 9:39 a.m., infection preventionist (IP) confirmed R34 was on EBP. IP stated her expectations were PPE would have been readily available to care for any residents in EBP and staff would wear PPE when indicated. IP indicated her expectation was for staff to perform hand hygiene after removing gloves and before administering any medications to a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 10:10 a.m., director of nursing (DON) stated her expectation was that PPE would have been readily available to care for any residents in EBP and staff would have worn a gown and gloves while caring for R34. DON indicated her expectation was for staff to perform hand hygiene after removing gloves and before administering any medications to a resident. A facility policy title Enhanced Barrier Precautions revised 8/22, identified EBP are used as an infection control and prevention intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. EBP employed targeted gown and glove use during high contact resident activities when contact precautions do not otherwise apply. Gowns and gloves are to be applied prior to performing the high contact activity. Examples of high contact activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. A facility policy titled Handwashing/ Hand Hygiene revised 8/19, identified the facility considered hand hygiene the primary means to prevent the spread of infections. Identified an alcohol -based hand rub containing at lest 62% of alcohol or an anti-microbial soap should have been used before and after direct contact with a resident. Further identified hand hygiene was the final step after removing and disposing of personal protective equipment. .