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	02/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 3 resident s (R30) who were observed to self-administer a nebulizer and had not been assessed as safe to self-administer medications.Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 3 resident s (R30) who were observed to self-administer a nebulizer and had not been assessed as safe to self-administer medications. R30's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had severe cognitive impairment and had diagnosis which included Alzheimer's depression, and chronic obstructive pulmonary disease (COPD/chronic lung disease that cause airflow and breathing problems). Further, R5 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. R30's care plan revised 1/25/26, identified R30 had altered respiratory status/difficulty breathing r/t COPD. SOB with exertion. R30's care plan interventions included to administer inhaled or other medications for treatment of respiratory conditions as ordered. Review of R30's electronic health record (EHR) lacked a self-administration of medication (SAM) assessment. R30's Order Summary Report signed 1/9/26, directed staff to administer DuoNeb 0.5-2.5 (3) mg /3ml inhalation solution Ipratropium-Albuterol) 3ml Further, it directed staff to administer Bu inhalation suspension via nebulizer four times daily for shortness of breath . R30's Order Summary Report lacked an order to self-administer medication. During a continuous observation on 2/10/26 at 12:15 p.m., R30 was lying in bed with a nebulizer mask on her face and steam coming out of the mask with no staff present. At 12:17 p.m., trained medication aide (TMA)-A entered R30's room turned the nebulizer machine off ,removed the nebulizer mask from R30's face, placed the nebulizer mask on a bedside table and left the room. During an interview on 2/10/26 at 12:22 p.m., TMA-A verified she had placed the nebulizer mask on R30, turned on the machine and left the room. TMA-A stated she administered the nebulizer because she turned the machine on and placed the mask on R30's face. TMA-A stated she was unsure if a SAM assessment had been completed for R30. TMA-A stated she was unsure what a [NAME] was and what the process was for a resident that did not have an order to self-administer medications. During an interview on 2/10/26 at 12:45 p.m., registered nurse (RN)-A confirmed there was not a [NAME] completed for R30. RN-A stated her expectation was nursing staff would have stayed in the room with R30 while she received the nebulizer treatments to ensure R30 received the nebulizer treatments appropriately. During an interview on 2/10/26 at 3:10 p.m., director of nursing (DON) verified R30 was not safe to self-administer medications. DON stated if a resident had not been assessed to safely self-administer medication or have a physician order to self-administer medications staff were expected to remain with the resident the entire nebulizer treatment. A facility policy titled Self-Administration of Medications revised 2021, identified the interdiciplinary team (IDT) would assess residents cognitive and physical abilities to determine is self-administering medications is safe for the resident. Identified if it were deemed to be safe and appropriate for a resident to self-administer medications it would be documented in the resident's clinical record.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess the use of a restrictive device as a potential restraint for 2 of 2 resident (R21, R5) reviewed for restraints. Findings Include: R21's quarterly Minimum Data Set, dated [DATE], identified R21 had severe cognitive impairment and diagnoses which included: stroke, dementia and arthritis. R21's MDS identified R21 required partial/moderate assistance with rolling left to right and lying to sitting. R21 required substantial/maximal assistance with sitting to standing and transfers. In addition, R21's MDS identified R21 has two or more falls with no injury and restraints were not used. R21's Care Area Assessment (CAA) dated 5/14/25, identified R21 was at risk for falls related to her impaired mobility and cognitive functions and need for activities of daily living (ADL) assistance. R21's CAA did not identify R21 used any restraints. R21's care plan revised 1/26/26, identified R21 was at risk for falls due to spinal stenosis, left possible rotator cuff injury, need for assistance with ADLs, confusion and other chronic diagnoses. R21's fall interventions included placing turn aides in R21's bed for repositioning. Review of R21's progress notes from 12/1/25 to 2/10/26, identified the following: -12/8/25 at 3:04 p.m.- R21 was found sitting on floor with back facing bed. No injuries noted. Interventions: place turn aides in R21's bed for repositioning. Review of R21's Order Summary Report signed 1/14/26, did not identify an order for a restraint. R21's medical record lacked any evidence that a restraint assessment had been completed. During observation on 2/9/26 at 2:46 p.m., R21 observed lying in bed, eyes closed. R21 had two cylinder-shaped blue pillows, approximately three and one half to four feet long and ten to twelve inches in height, on both sides of R21. The blue pillows were attached to a blue draw sheet under R21. During observation on 2/10/26 at 9:45 a.m., R21 was not in room. R21's bed had two cylinder-shaped blue pillows and draw sheet lying across the foot of bed. During interview on 2/10/26 at 11:42 a.m., nursing assistant (NA)-B indicated R21 was at risk for falls. NA-B stated the turning aide pillows were put in place around a few months ago. NA-B stated R21 will put her legs over the pillow but was unsure if R21 was able to get out of bed with them in place. NA-B indicated she thought the turning aid pillows were for repositioning, and to slow R21 down from falling out of bed so much. During interview on 2/10/26 at 1:55 p.m. clinical manager registered nurse (RN)-D confirmed R21 was at risk for falls and turn aide pillows were an intervention put in place to help reduce falls. RN-D stated she had observed R21 crawl over them in the past and thought R21 would still be able to get out of bed with them in place. RN-D stated the facility did complete restraint assessments but (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated R21 did not have one completed. RN-D stated was unsure if the turning aid pillows would be considered a restraint. R5 R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 was moderately cognitively impaired. R5 had a diagnosis of atrial fibrillation (irregular heart rhythm), coronary artery disease (plaque buildup in arteries, which can lead to reduced blood flow to the heart), and Alzheimer's disease (neurodegenerative disease affecting memory, thinking, and behavior). R5 required maximal assistance to roll left and right in bed and was dependent on staff to transition from a sitting to a lying position and from a lying to a sitting position in bed. R5 was dependent on staff for transferring in and out of bed. R5's care plan revised on 1/25/26, indicated R5 was dependent on staff to sit up in bed, dependent on staff to lie down in bed, dependent on staff when getting out of bed, and needed maximal assistance when rolling in bed. R5's care plan revealed R5 would have turned aids on while in bed for fall intervention from 1/30/26, starting on 2/2/26. R5's medical record lacked any evidence that a restraint assessment had been completed. During an observation and interview on 2/10/26 at 11:18 a.m., R5 was lying on a blue draw sheet; the ends of the blue draw sheet had a cylinder holder attached by sewing for pillows, the pillows were to be zipped in. There were two pillows in the holders on the ends, and were both hanging off the side of the bed. A licensed practical nurse (LPN)-A indicated that the pillows could be removed and the draw sheet could be sent to laundry. LPN-A indicated if a resident were a fall risk, the pillows would help prevent falls, and the pillows can be used for repositioning; the device was called a turn aid in the care plan. During an observation on 2/10/26 at 12:02 p.m., R5 was in bed with eyes closed, and a blue draw sheet was under R5 with pillows on the side of R5's body. Pillows were approximately the same height and close to the same length as R5. The pillows were not tucked under resident at that time for repositioning. During an interview on 2/10/26 at 2:18 p.m., registered nurse (RN)-B indicated the facility did not do a restraint assessment for the blue turn aids, and R5 received the blue turn aids as an intervention after a fall. During an interview on 2/11/26 at 12:30 p.m., nursing assistant (NA)-C indicated R5 received the blue turn aids after a fall. NA-C indicated the blue turn aids were to help prevent falls and could be used to help turn and reposition a resident. NA-C did not believe R5 would be able to get over the pillows if she wanted to. During an interview on 2/11/26 at 12:31 p.m., NA-A indicated the blue turn aids were used for repositioning and believed if R5 had gotten her feet over the pillows, there would be a possibility she would have been able to roll over the pillows. During an interview on 2/11/26 at 10:30 a.m., LPN-A indicated R5 were able to get her feet on the blue turn aid pillows, but was unsure if R5 would be able to sit up on the edge of the bed if R5 desired. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/26 at 2:07 p.m., director of nursing (DON) indicated the turn aid pillows were used for comfort. DON indicated the turn aid pillows could be considered a restraint if a resident was unable to get over the pillows. The DON's expectation would be for staff to follow the policy on restraints. Policy titled use of restraints, dated 4/17, indicated physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The definition of restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it, given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; tucking sheets so tightly that a bed-bound resident cannot move; placing a resident in a chair that prevents the resident from rising; and placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. Restraints maybe only be sued if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medial symptom; protect the resident safety; and help the resident attain the highest level of his/her physical or psychological well-being. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions, programs, devices, referrals, etc.) that may improve the symptoms.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure that routine shaving was provided for one of two (R18) individuals reviewed for activities of daily living (ADLs) who were dependent on staff for their care. Findings include: R18's brief interview for mental status (BIMS) revealed R18 had severe cognitive impairment. R18 functional abilities and goals (GG) evaluation dated 2/6/26, indicated R18 needed moderate assistance for ADLS and was set up for oral hygiene. R18's functional abilities and goals assessment dated [DATE], indicated R18 needed moderate assistance for ADLs. R18's signed order summary report dated 2/11/26, revealed R18 had a diagnosis of kidney failure, malignant neoplasm of the bladder (bladder cancer), and palliative care. R18 received hydromorphone hydrochloride (HCL) 2 milligrams (mg) two times a day for pain. R18's care plan dated 1/27/26, indicated R18 needed assistance for ADLs. R18's progress notes dated 2/5/26 to 2/10/26 did not identify R18 as refusing cares such as shaving. During an observation on 2/9/26 11:54 a.m., R18 was sitting in a recliner in his room with approximately 0.5 centimeters (cm) of facial hair on R18's neck, chin, and sides of face. R18 had a mustache was trimmed to the upper lip. During an observation on 2/10/26 at 8:50 a.m., R18 was in the dining room eating breakfast with 0.5 of facial hair on the neck, chin, and side of face. During an observation on 2/10/26 at 3:17 p.m., R18 was sitting in the living room in a recliner and had approximately 0.5 cm of facial hair on the neck, chin, and sides of the face. During an observation on 2/11/26 at 7:16 a.m. RN-A went into R18's room and assisted R18 with getting dressed. R18 had approximately 0.5 to 1 cm of facial hair on the neck, chin, and sides of the face. R18 indicated that he wanted to brush his teeth and shave after breakfast. During an observation on 2/11/26 at 8:10 a.m., R18 was served breakfast in the dining room. During an observation on 2/11/26 at 8:50 a.m., R18 finished eating breakfast, and staff walked him to a recliner by the dining room and sat him down in the recliner. Staff placed a wheeled side table in front of him. Staff did not offer to shave him or brush his teeth. During an observation on 2/11/26 at 10:19 a.m., R18 was sitting in a recliner in the living room, eating a snack. R18 has approximately 0.5 to 1 cm of facial hair on the neck, chin, and cheeks. During an interview on 2/10/26 at 9:57 a.m., nursing assistant (NA)-A indicated R18 needed help with all ADLs. NA-A indicated staff would shave him if R18 requested to be shaved. NA-A also indicated R18 had been requiring more assistance than when he was first admitted . During an interview on 2/10/26 at 10:02 a.m., family member (FM)-A indicated R18 preferred to be shaved daily. FM-A would expect staff to prompt R18 to shave daily. FM-A reported his shaver had been brought in for staff to use on R18. During an interview on 2/11/26 at 9:14 a.m., RN-A indicated if a resident refused cares it should be documented either by the NA in the tasks or in a progress note by a nurse. RN-A expectation would be for staff to offer shaving daily and reapproach at a later time if the resident refuses. RN-A verified that she had not shaved R18 after breakfast. During an interview on 2/11/26 at 10:11 a.m., NA-B indicated R18 needed assistance with ADLs, and if R18 refused care, staff would reapproach later. NA-B indicated if a resident refused cares the NA would chart refusal of cares and would notify the nurse. NA-B indicated it would be in the resident care plan on how they wanted to be shaved or would ask the resident their preference. NA-B indicated R18 preference was to have a mustache and did not want it to be shaved. NA-B indicated R18 was shaved last week when NA-B did R18's cares, but NA-B did not attempt do R18's cares this shift. During an interview on 2/11/26 at 10:21 a.m., NA-C indicated if when a resident would refuse cares it would be charted, and staff would attempt ADL care at a later time. NA-C indicated she has not attempted R18's cares that shift. During an interview on 2/11/26 at 10:30 a.m., licensed practical nurse (LPN)-A indicated R18 was dependent on staff for ADL care. LPN-A indicated if a resident refused cares the nursing assistants should notify the nurse. LPN-A indicated the nursing assistants did not reported R18 had refused shaving. LPN-A indicated the nursing assistants were to chart refusal of care in the task section of the NA charting. During an interview on 2/11/26 at 9:29 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., Director of nursing (DON) indicated residents should be shaved per their preference and staff to document refusal. Policy titled Shaving the resident, revised 2/18, identified if the resident refused shaving, the reason why and the intervention taken should be documented in the resident's medical record. Notify the supervisor if the resident refuses the procedure. Policy titled activities of daily living, supporting revised on 3/18, revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problems and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate.

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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** Based on observation and interview, the facility failed to disinfect a multi-use glucometer (a machine that is used for blood glucose monitoring) after use for 1 of 2 residents (R41) reviewed for blood glucose monitoring. Further the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 3 residents (R62) 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). Review of Manufactures guidelines for Assure Platinum multi Blood Glucose Monitoring System (BGMS) revised 9/24, identified disinfecting the glucometer was to be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe, after every resident use. Identified ,what would happen when a blood glucose meter was not cleaned and disinfected after use. Per the CMS F-Tag 880 guideline, surveyors may issue a citation if they observed no cleaning and disinfecting of meters after a blood glucose test as they would not be in compliance with CMS F-Tag 880. 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. R41's quarterly Minimum Data Set (MDS) dated [DATE] identified R15 had intact cognition and diagnoses which included hypertension (elevated blood pressure), renal insufficiency and diabetes mellitus (DM). R41's current physician orders signed 1/13/26, identified R15 required blood glucose monitoring checks before meals and at bedtime. During an observation on 2/9/26 at 11:45 a.m., licensed practical nurse (LPN)-A sanitized hands, applied gloves and removed a glucometer, strip and a lancet (small device with a needle used to get blood for blood glucose monitoring) from the top drawer of the medication cart. RN-A used the lancet to poke R41's finger and obtained a small drop of blood onto the glucometer strip. LPN-A removed gloves, sanitized hands and wiped the glucometer with an alcohol pad and placed the glucometer into the medication cart. During an interview on 2/9/26 at 11:51 a.m., LPN-A verified she had wiped the glucometer which was used for multiple residents with an alcohol pad prior to placing it in the medication cart. LPN-A stated she should have disinfected the glucometer per manufacturer's guidelines with a sani-wipe prior to placing it into the drawer of the medication cart to prevent the spread of blood-borne infections. During an interview on 2/10/26 at 1:57 p.m., infections preventionist (IP) verified the glucometer in the top drawer of the medication cart was used for multiple residents. IP stated their expectation was that the glucometer would have been disinfected between residents using a Sani-wipe or per manufacturer's guidelines to prevent blood- borne infections. (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 2/10/26 at 2:57 p.m., director of nursing (DON) stated most residents had their own glucometer but at times staff need to use a shared glucometer. DON stated her expectation was that the glucometer would have been disinfected between residents using a Sani-wipe or per manufacturer's guidelines to prevent blood- borne infections. Review of Manufactures guidelines for Assure Platinum multi Blood Glucose Monitoring System (BGMS) revised 9/24, identified disinfecting the glucometer was to be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe, after every resident use. Identified ,what would happen when a blood glucose meter was not cleaned and disinfected after use. Per the CMS F-Tag 880 guideline, surveyors may issue a citation if they observed no cleaning and disinfecting of meters after a blood glucose test as they would not be in compliance with CMS F-Tag 880. Review of a facility policy titled Cleaning and Disinfection of Resident Care items and Equipment revised 9/22, identified reusable items are cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations between residents. EBP R62's signed order summary report, signed 2/9/26, identified R62 of having a diagnosis of aftercare following surgery for neoplasm (abnormal growth of cells resulting in a tumor) and acquired absence of left breast. Order summary identified R62 had orders for oxycodone hydrochloride (HCl) 4 milligrams (mg) every 4 hours as needed for acute pain related to aftercare following surgery for neoplasm. R62's care plan, initiated on 2/6/26, identified R62 required enhanced barrier precautions (EBP) for high contact activities while in the resident's room. R62's electronic medical administration record (EMAR) identified staff were to empty Jackson Pratt (JP, a device used to remove fluid from the wound helping to prevent infection and promote healing after surgery) drain to left mastectomy site and record output. Staff were to check tube placement to prevent dislodgement every shift. R62's skin assessment dated [DATE], identified a left chest mastectomy incision site. During an observation on 2/11/26 at 9:03 a.m., registered nurse (RN)-C knocked on R62's door. A plastic storage container was next to the door with gowns, gloves, and goggles. There was a sign on the door identifying R62 as being on enhanced barrier precautions. RN-C went into room, washed her hands, and applied gloves, but did not apply a gown. RN-C obtained a urinal container from the bathroom and emptied the JP drain. RN-C discarded the contents in the urinal, removed gloves, and washed hands. RN-C left 62's room. During an interview on 2/11/26 at 9:09 a.m., RN-C indicated a gown should have been worn when emptying R62's JP drain, as R62 is on EBP to protect R62 from infections. During an interview on 2/11/26 at 9:12 a.m., RN-A expectation were for staff to be wearing gowns when a resident was on EBP to decrease the risk of infection. RN-A verified R62 was on EBP and had a JP drain. (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 2/11/26 at 9:32 a.m., director of nursing (DON) stated her expectation was for staff to wear gowns when a resident was on EBP to help prevent the spread of infection. Review of enhanced barrier precautions policy dated 12/24 identified enhanced barrier precautions (EBPs) are utilized to prevent the spread of multidrug-resistant organisms (MDROs) to residents. EBPs employ target gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing the high-contact resident care activities. Examples of high-contact resident care activities requiring the use of a gown and gloves for EBPs include device care of use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.), and wound care.