DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

			AND TRANSMITTAL ΓΕ SURVEY AGENCY		0: 08FG acility ID: 00013
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245489 2.STATE VENDOR OR MEDICAID NO. (L2) 726040700 5. EFFECTIVE DATE CHANGE OF OWNERSHIP	(L3) EMMANUEI (L4) 1415 MADISO (L5) DETROIT LA		(L6) 56501	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint 9. Other
(L9) 6. DATE OF SURVEY		05 HHA 09 ESRD 06 PRTF 10 NF 07 X-Ray 11 ICF/III 08 OPT/SP 12 RHC	13 PTIP 22 CLIA 14 CORF) 15 ASC 16 HOSPICE	8. Full Survey After C FISCAL YEAR ENDING 09/30	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 102 (L18) 13. Total Certified Beds 102 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 102 (L37) (L38) (L39)	B. Not in Compli Requirements a	nce With quirements Based On: ceptable POC ance with Program and/or Applied Waivers: IID (L43)	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Server 7. Medical Direction	vices Limit ctor
16. STATE SURVEY AGENCY REMARKS (IF APPL 17. SURVEYOR SIGNATURE Gail Anderson, Unit Supervisor BART H. TO E	Date : 06	5/09/2016 (L19)	18. STATE SURVEY AGENCY.	Enforcement Speciali	Date: 07/26/2016 (L20
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2)	20. COME RIGHT	PLIANCE WITH CIVIL TS ACT:	21. 1. Statement of Finan	cial Solvency (HCFA-2572) I Interest Disclosure Stmt (F	
01/01/1987 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERN A. Susper	EEMENT 24. ING DATE ATIVE SANCTIONS asion of Admissions: d Suspension Date:	LTC AGREEMENT ENDING DATE (L25) (L44)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal		30) FARY eet Health/Safety eet Agreement Status Change
28 TERMINATION DATE:	29 INTERMEDIARY/C	(L45)	30 REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

03001

06/01/2016

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245489

July 26, 2016

Ms. Janet Green, Administrator Emmanuel Nursing Home 1415 Madison Avenue Detroit Lakes, Minnesota 56501

Dear Ms. Green:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 21, 2016 the above facility is certified for:

102 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 102 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 9, 2016

Ms. Janet Green, Administrator Emmanuel Nursing Home 1415 Madison Avenue Detroit Lakes, Minnesota 56501

RE: Project Number S5489025

Dear Ms. Green:

On April 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 16, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective May 21, 2016 and therefore remedies outlined in our letter to you dated April 29, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVISIT	Г
IDENTIFICATION NUMBER	A. Building			I	
245489 _{Y1}	B. Wing	Y	Y2	6/6/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
EMMANUEL NURSING HOME		1415 MADISON AVENUE			
		DETROIT LAKES, MN 56501			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	VI	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. #	F0282 483.20(k)(3)(ii)	Completed	ID Prefix F03 483 Reg. #	.25(a)(3)	Correction Completed	ID Prefix		Correction
LSC		05/21/2016	LSC		05/21/2016	LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
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FOLLOWUP TO SURVEY COMPLETED ON 4/21/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					s 🗆 no	

		POST	-CERT	TIFICATION	N REVISIT RE	EPORT	-		
	R / SUPPLIER / CLIA /	MULTIPLE CONS						DATE O	F REVISIT
1DENTIFI 245489	CATION NUMBER Y1	A. Building 01 - B. Wing	2004 BUIL	DING 2008 KITCH	EN ADDITION		Y2	5/16/20	16 _{Y3}
NAME OF	FACILITY				STREET ADDRESS, CIT	Y, STATE, ZII	P CODE		
EMMAN	UEL NURSING HOME				1415 MADISON AVENUE				
					DETROIT LAKES, MN 56	5501			
corrected provision	This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments or orgram, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).								
ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4	!	Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg.#	NFPA 101	Completed	Reg.#	NFPA 101		Completed
LSC	K0018	04/22/2016	LSC	K0022	04/22/2016	LSC	K0029		04/22/2016
						-			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg.#			Completed
LSC	K0062	05/13/2016	LSC			LSC			

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POST-CERTIFICATION REVISIT REPORT

	FOLLOWUP TO SURVEY COMPLETED ON			N	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?								
REVIEWE CMS RO	D BY		REVIEWED (INITIALS)	ву	DATE		TITLE					DATE	
		X	REVIEWED (INITIALS)	в у TL/mm	DATE 06/09/	2016	SIGNATUR	RE OF SURV	/EYOR 3653	36		DATE 05/16/	/2016
LSC					LSC					LSC			
Reg.#			C	Completed	Reg. #			C	completed	Reg.#			Completed
ID Prefix			C	Correction	ID Prefix			C	Correction	ID Prefix			Correction
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ID Prefix			C	Correction	ID Prefix			C	Correction	ID Prefix			Correction
LSC	K0022		0	4/22/2016	LSC	K0029		0-	4/22/2016	LSC			
Reg. #	NFPA 10	1	C	Completed	Reg. #	NFPA 1	01	C	completed	Reg.#			Completed
ID Prefix			C	Correction	ID Prefix			C	Correction	ID Prefix			Correction
Y4	п			Y5	Y4				Y5	Y4			Y5
program, corrected provision the surve	to show and the number y report	those of date su and the	deficiencies pr uch corrective	reviously repo action was a prefix code p	rted on the (ccomplished	CMS-25	67, Statem deficiency	nent of Def should be	iciencies and fully identifie	Plan of Corr d using eithe	ection, that have r the regulation o	been or LSC	DATE
EMMANU	JEL NUF	SING F	HOME						1415 MADISON AVENUE DETROIT LAKES, MN 56501				
NAME OF	FACILIT	′	<u>, </u>					STREET A	DDRESS, CIT	Y, STATE, ZIP	CODE		
IDENTIFIC 245489	A. Buildir B. Wing ME OF FACILITY MANUEL NURSING HOME se report is completed by a qualified State gram, to show those deficiencies previous rected and the date such corrective action in number and the identification prefix across the following survey report form). ITEM DAY YA Y Prefix Correct # Completed by a qualified State gram, to show those deficiencies previous rected and the date such corrective action prefix across the following survey report form). ITEM DAY YA Y Prefix Correct # Completed by a qualified State gram, to show those deficiencies previous rected and the identification prefix across the following survey report form). Complete State gram, to show those deficiencies previous rected and the identification prefix gram across the identification prefix across the following survey report form). Complete State gram across the following survey report form and the identification prefix gram across the identification prefix gram across the following survey report form). Complete State gram, to show those deficiencies previous across the following survey report form across the identification prefix gram across the following survey report form). Complete State gram across the following survey report form).			•	1963 MAIN	BUILD	NG				Y2	5/16/201	6 _{Y3}
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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT						
IDENTIFICATION NUMBER	A. Building 03 - BUILDING 3								
245489 _{Y1}	B. Wing	Y2	5/16/2016	Y3					
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE							
EMMANUEL NURSING HOME		1415 MADISON AVENUE							
		DETROIT LAKES, MN 56501							
This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments									

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEI Y4		DATE Y5	ITEM	DATE Y5	ITEM Y4		DATE Y5	
Y4		15	Y4		14			
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg.#	NFPA 101	Completed	Reg. #	Completed	Reg. #		Completed	
LSC	K0022	04/22/2016	LSC		LSC _		-	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC		-	
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LSC			LSC		LSC		-	
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Reg.#		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC		-	
REVIEWED BY STATE AGENCY X (INITIALS) TL/mm		REVIEWED BY (INITIALS) TL/mm	DATE 06/09/2016	SIGNATURE OF SURVEYOR 3653	SURVEYOR 36536		6/2016	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE		
FOLLOWUP TO SURVEY COMPLETED ON 4/19/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	08FG
Fac	ility ID: 00013

1. MEDICARE/MEDICAID PROVIDIO (L1) 245489 2.STATE VENDOR OR MEDICAID NO (L2) 726040700		3. NAME AND AD (L3) EMMANUE (L4) 1415 MADIS (L5) DETROIT L	L NURSING I SON AVENUE	HOME	(L6) 56501		 TYPE OF ACTION Initial Termination Validation 	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 04/21 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	OWNERSHIP //2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	14 CORF	CLIA F	7. On-Site Visit 8. Full Survey After FISCAL YEAR ENDIN 09/30	<u> </u>
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	102 (L18) 102 (L17)	X B. Not in Com	equirements e Based On: cceptable POC	gram	And/Or Approved Wa 2. Technical F 3. 24 Hour RN 4. 7-Day RN (5. Life Safety * Code: B*	Personnel N (Rural SNF) Code	Following Requireme 6. Scope of Se 7. Medical Dir 8. Patient Roor 9. Beds/Room	rvices Limit ector
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 102 (L37) (L38)	WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 ((L15)	
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE Date : Tammy Williams, HFE NEII 05/23/2016						AGENCY AP الاصلا م nforcement	neath	Date: 06/01/2016 (L20)
PA	RT II - TO BE	COMPLETED H	BY HCFA RE	(L19) EGIONAI	OFFICE OR SIN	GLE STA	TE AGENCY	(L20)
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 2. Facility is not Eligible	JTY Participate	20. COM	IPLIANCE WITH		 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24) 25. LTC EXTENSION DATE: (L27)		G DATE	4. LTC AGREEM ENDING DATE (L25) (L44) (L45)		26. TERMINATION A VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/F 03-Risk of Involuntary T 04-Other Reason for Wi		INVOLUN 05-Fail to N 06-Fail to N OTHER	L30) TARY Meet Health/Safety Meet Agreement r Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION 06/01/2016	OF APPROVAL	LDATE (L33)	DETERMINATIO	N APPRO	VAL	
		-						



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 29, 2016

Ms. Janet Green, Administrator Emmanuel Nursing Home 1415 Madison Avenue Detroit Lakes, MN 56501

RE: Project Number S5489025

Dear Ms. Green:

On April 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Emmanuel Nursing Home April 29, 2016 Page 2

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 31, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 31, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Emmanuel Nursing Home April 29, 2016 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 21, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Emmanuel Nursing Home April 29, 2016 Page 5

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date

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 October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

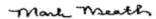
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525 Emmanuel Nursing Home
April 29, 2016
Page 6
Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 05/23/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED	
		245489	B. WING	 	04/21/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENT	-S	F 000		
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 aic submission of the POC will ion of compliance.			
F 282 SS=D	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 483.20(k)(3)(ii) SERVICES BY QUALIFIED		F 282		5/21/16
	must be provided by	led or arranged by the facility y qualified persons in ch resident's written plan of			
	by: Based on observat review, the facility fa directed by the indiv resident (R7) who r grooming. Finding include: R7's care plan, revi had self care deficit and grooming due t osteoarthritis. The o	ion, interview and document ailed to provide assistance as vidualized care plan for 1 of 3 equired staff assistance for sed on 8/26/15, indicated R7 related to bathing, dressing to obesity, osteoporosis, and care plan identified R7 was dimacular degeneration and		F 282 Services by qualified persons pare plan The only female resident who had fact hair had refused hair removal from several people, multiple times; includi NARs, nurses, and the beautician. Shallowed the nurse to assist her in shar on April 21st at lunch time but did complain and stated she did not like to shaved. Her daughter stated she wou bring in a new razor for facial hair removal. NARs will use the razor in the beauty shop until the new razor is	ial ing ne ving peing ild
ABORATOR)	V DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

05/06/2016

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.

OLIVILI	10 I OIT WILDIOAITE	A MEDICAID SETVICES			<u> </u>	VID NO.	0900-0091
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		SURVEY PLETED
		245489	B. WING	i		04/2	21/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1.	415 MADISON AVENUE		
EMMAN	JEL NURSING HOME			D	DETROIT LAKES, MN 56501		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLÉTION DATE
F 282	Continued From pa	ae 1	, F	282			
	·	o assist R7 with grooming,			available.		
	bathing and dressing				The current plan of care did state the	nat she	
	battiling and arcoon	·9·			frequently refuses shaving and ass		
	During observation	on 4/19/16 at 10:49 a.m. R7			from staff members. Staff members		
		white, thick facial hair on her			her on a daily basis.		
		ended over her lip area and			To identify others at risk:		
		and cheek areas. The facial			A questionnaire was handed out to	over	
	hairs were approxir	nately 1/4 inch or longer. At			50 NARs, nurses, Life enrichment		
		al hair remained the same.			and social workers asking them to		
					residents who routinely refuse treat	ments,	
	During observation	on 4/20/16 at 7:14 a.m. R7			cares, medications, or activities. The	nese	
	was noted to be lay	ring on her bed listening to a			names were reviewed and issues		
		ecorder. R7 had white, thick,			addressed individually to make sur	e their	
		n her upper lip which extended			needs are met.		
		d onto her entire chin and			Systemic Changes:		
		facial hair were approximately			An educational in-service will be		
		At 7:27 a.m. R7 wheeled			presented to NARs, and nurses on		
		oom in the wheelchair,			communicating better with resident		
		elchair with her feet and her			refuse or are resistant to cares with		
		dining room for breakfast. At all hair was observed to remain			emphasis on how to phrase a requ give time to process and answer ar		
	the same.	ai ilali was observed to reilialii			promote positive responses on Ma		
	the same.				5, and 9, 2016. The education will a		
	During observation	on 4/21/16 at 9:43 a.m. R7			cover who and when and how to re		
		hop getting her hair done by			device not working or need for new		
		had white, thick, coarse facial			equipment.		
		which extended over her lip			Monitoring:		
		entire chin and cheek areas.			The nurse completes a weekly skir	1	
		re approximately 1/4 inch or			assessment which is recorded in the	ie	
		auty shop appointment, at			EMAR. Checking for facial hair was		
		observed and the thick, white			to provide a weekly monitoring by t		
		the same on her lip, chin and			nurse with documentation of refusa		
	cheek areas.				this time. The clinical RN and the s		
					worker will monitor on a bi-weekly b	oasis X	
	On 4/21/16 at 11:42 a.m. the thick, white, long				4 then move to monthly x3.		
		d present on R7's upper lip,			Ongoing compliance:		
		a. R7 stated in the past she			Concerns will be immediately hand	led and	
		because her chin hair was the			brought to the QAPI meeting for		
	most bothersome.	She indicated staff usually did			discussion and to determine furthe	r	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED				
		245489	B. WING		·····	04/	21/2016		
	PROVIDER OR SUPPLIER JEL NURSING HOME			14	REET ADDRESS, CITY, STATE, ZIP CODE 15 MADISON AVENUE ETROIT LAKES, MN 56501				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TION SHOULD BE THE APPROPRIATE			
F 282	not help her with stried, the razor doe bother with it." R7 bothered her and son my face." R7 st forward and put on face." R7 indicate razor but the razor use. R7 indicated facial hair shaved of the she had clean cloth used to have disposallowed to use then and stated "I do not that works." NA-A in with that much facis. On 4/21/16 at 12:00 (DON) confirmed Findicated R7 had prassistance with groexpectation of staff on a daily basis to be indicated if the razor expect staff to reponew razor and state be offering to shave assist R7 to get a ristated she expecte as written and indicated razors to use within not working proper.	naving and stated "they have is not work, so they don't indicated the facial hair tated "I wish I did not have it ated "I like to put my best face a smile, but I have hair on my dishe used to have her own was no longer safe for her to she would like to have the off. Dial. a.m. nursing assistant (NA)-A tinely assisted R7 with set upper clothes out and made sure nes on. NA-A indicated R7 sable razors and she was not in, so she got an electric razor that know if she got a new razor indicated that usually residents all hair should be shaved. Dial. p.m. director of nursing R7's current care plan and foor vision and required from and required for would be to offer and ask R7 for shaved. The DON also for was not working, she would for it, so they could get R7 a feel she felt overall staff should find the rand the facility would find the rand the facility would find the staff to follow the care plan facted staff had other alternative in the building if R7's razor was	F 2	882	interventions for on-going compliar all residents. Responsible Parties: Clinical RNs, Worker, DON, Administrator Completion date: May 21, 2016				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED	
		245489	B. WING		04/21/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
F 282 F 312 SS=D	that care is planned residents/patients h mental, and psycho	I to attain or maintain the ighest practicable physical, social well being. FARE PROVIDED FOR	F 282 F 312		5/21/16
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal			
	by: Based on observatinterview, the facility assistance for 1 of assistance with gro Findings include: R7's quarterly Mining 2/16/16, indicated Fincluded: demential degeneration. The cognition and requipersonal hygiene, of R7's care plan, revihad self care deficit and grooming due to osteoarthritis. The collegally blind and had directed staff was to bathing and dressing the same series of the same self-care deficit and grooming due to osteoarthritis. The collegally blind and had directed staff was to bathing and dressing the same self-care for t	num Data Set (MDS) dated R7 had diagnoses which legal blindness, and macular MDS identified R7 had intact red extensive assistance for lressing, toileting, and bathing. Sed on 8/26/15, indicated R7 related to bathing, dressing to obesity, osteoporosis, and care plan identified R7 was diagraphic macular degeneration and passist R7 with grooming,		F 312 ADL Care provided for depend resident The only female resident who had fact hair had refused hair removal from several people, multiple times; includi NARs, nurses, and the beautician. Shallowed the nurse to assist her in shar on April 21st at lunch time but did complain and stated she did not like the shaved. Her daughter stated she wou bring in a new razor for facial hair removal. NARs will use the razor in the beauty shop until the new razor is available. The current plan of care did state that frequently refuses shaving and assist from staff members. Staff members a her on a daily basis. To identify others at risk: A questionnaire was handed out to over 50 NARs, nurses, Life enrichment state and social workers asking them to idea residents who routinely refuse treatments.	ng ne ving peing Id e she ance ask er ff,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	SURVEY PLETED
		245489	B. WING			04/2	21/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501	<i>-</i>	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	was noted to have upper lip which externation hairs were approxing 3:06 p.m. R7's facial buring observation was noted to be lay storybook on her recoarse facial hair of over her lip area and cheek areas. R7's 1/4 inch or longer. Wherself out of her repropelling the wheek hands to go to the of 1:30 p.m. R7's facial hair on her upper lip area and onto her extended to shave often most bothersome. On 4/21/16 at 11:42 facial hair remained cheek areas. On 4/21/16 at 11:42 facial hair remained cheek areas. On 4/21/16 at 11:42 facial hair remained cheek areas. On 4/21/16 at 11:42 facial hair remained cheek areas. On 4/21/16 at 11:42 facial hair remained cheek areas.	white, thick facial hair on her ended over her lip area and and cheek areas. The facial mately 1/4 inch or longer. At all hair remained the same. on 4/20/16 at 7:14 a.m. R7 ring on her bed listening to a ecorder. R7 had white, thick, in her upper lip which extended and onto her entire chin and facial hair were approximately At 7:27 a.m. R7 wheeled from in the wheelchair, elchair with her feet and her dining room for breakfast. At all hair was observed to remain on 4/21/16 at 9:43 a.m. R7 hop getting her hair done by had white, thick, coarse facial of which extended over her lip entire chin and cheek areas. The approximately 1/4 inch or auty shop appointment, at observed and the thick, white of the same on her lip, chin and all are approximated in the past she because her chin hair was the She indicated staff usually did naving and stated "they have so not work, so they don't indicated the facial hair tated "I wish I did not have it	F3	312	cares, medications, or activities. The names were reviewed and issues addressed individually to make surneeds are met. Systemic Changes: An educational in-service will be presented to NARs, and nurses on communicating better with resident refuse or are resistant to cares with emphasis on how to phrase a requigive time to process and answer ar promote positive responses on May 5, and 9, 2016. The education will a cover who and when and how to redevice not working or need for new equipment. Monitoring: The nurse completes a weekly skin assessment which is recorded in the EMAR. Checking for facial hair was to provide a weekly monitoring by the nurse with documentation of refusatistime. The clinical RN and the sworker will monitor on a bi-weekly then move to monthly x3. Ongoing compliance: Concerns will be immediately hand brought to the QAPI meeting for discussion and to determine further interventions for on-going compliantall residents. Responsible Parties: Clinical RNs, Worker, DON, Administrator Completion date: May 21, 2016	e their s who an est, ad y 3, 4, also port a le s added ne floor als at ocial basis X led and ce for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245489	B. WING			04/	21/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501	, , , , ,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	on my face." R7 st forward and put on face." R7 indicate razor but the razor use. R7 indicated facial hair shaved of the facial hair shaved is the facial hair shaved in the f	ated "I like to put my best face a smile, but I have hair on my d she used to have her own was no longer safe for her to she would like to have the off. Defended as a management of the she would like to have the off. Defended as a management of the she would like to have the off. Defended as a management of the she was not an	F3	312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT COM	E SURVEY MPLETED
		245489	B. WING		04/	21/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COE 1415 MADISON AVENUE DETROIT LAKES, MN 56501		= 1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312		ge 6 sary to keep them clean and	F3	12		

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PRINTED: 05/10/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - 2004 BUILDING 2008 KITCHEN ADDITION 245489 B. WING 04/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1415 MADISON AVENUE **EMMANUEL NURSING HOME DETROIT LAKES, MN 56501** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY Building 01 - 1963 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey Emmanuel Nursing Home Building 01 - 1963 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/06/2016

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.

Facility ID: 00013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			LTIPI	LE CONSTRUCTION		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		LDING 01 - 2004 BUILDING 2008 KITCHEN		COMPLETED	
		245489	B. WING	-		04/	19/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME	Ē		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 000	Continued From pa 445 Minnesota Str St. Paul, MN 5510 Or by email to: Marian.Whitney@s and Angela.Kappenma	eet, Suite 145 1 state.mn.us	K	000		ь	
	THE PLAN OF CORRECTION FOR DEFICIENCY MUST INCLUDE ALL FOLLOWING INFORMATION: 1. A description of what has been, of to correct the deficiency.	ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done					
	3. The name and/oresponsible for cor	or title of the person rection and monitoring to ence of the deficiency.				8	
	The Emmanuel Nu as a 1-story buildin basement and was construction. In 19 was constructed, a and are Type II (11 addition to the nort building was construction, and is barrier. A chapel at 1992 and attached building, is 1-story determined to be on 1997 a sleeping ro	pected as 3 buildings: Irsing Home was built in 1963 g with a partial walkout determined to be Type II (111) 66 addition to the east wing re 1-story without basements 1) construction. In 1978 an h of the north wing of the 1963 ructed, is 1-story with a partial termined to be of Type II (000) s separated with a 2-hour fire ddition was constructed in to the south of the 1963 with a basement and was f Type II (000) construction. In om addition was constructed to 8 addition, is one story without					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245489	A, BUILDING ADDITION	G 01 - 2004 BUILDING 2008 KITCHEN	COMPLETED			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501	04/	19/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE	(X5) COMPLETION DATE
	construction. In 20 02) was constructed building, is 1-story is a Type II (000) or a 2-hour fire rated expansion (building south west corner full basement and is assisted living building and was determine construction. In 20 (building 03) was a be of Type II (111) or The building is compautomatic fire spring with NFPA 13 Stand Sprinkler Systems fire alarm system the corridor smoke detection in all compactor and with NI Alarm Code" 1999 automatic fire detection in all compactor and the single station smoked rooms that annuncing stations in accordance of the Code 2007 edicated the single station smoked fire code 2007 edicated the single sta	hich is a Type II (111) 04 a separate building (building of west of the 1963 main with a partial basement, which construction and separated with barrier. In 2008 a kitchen go 02) was constructed to the of the 1963 building, is 1-story, is separated form the new ding with a 2-hour fire barrier of to be Type II (111) 14 the Transitional Care Unit dded and was determined to construction. Inpletely protected with an ackler system in accordance dard for the Installation of 1999 edition. The facility has a mat includes 30-foot on center ection, with additional amon areas installed in FPA 72 "The National Fire edition. Hazardous areas have cors that are on the fire alarmine with the Minnesota State 1997 and 2004 additions have be detection in the sleeping lates at the respective nurse's ince with the Minnesota State at the respective nurse's ince with the Minnesota State tion.	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 2004 BUILDING 2008 KITCHEN ADDITION			TE SURVEY MPLETED
		245489	B. WING		04	/19/2016
NAME OF PROVIDER OR SUPPLIER EMMANUEL NURSING HOME		:		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501		Э
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 018 SS=E	Doors protecting or required enclosure hazardous areas s as those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist the impediment to the open devices that repushed or pulled an provided with a medoor closed. Dutch permitted. Door frast made of steel or otwith 8.2.3.2.1. Rolled CMS regulations in 19.3.6.3. This STANDARD is Based on observate facility failed to mai 4 corridor doors act section 19.3.6.3.1. affect the safety of undetermined amo smoke from a fire waccess corridors mediately in the frame. On the facility tour leading include: On the facility tour leading include: Nesident room, 2. Memory care roll.	between 7:30 to 1:30 on ations and staff interview ing corridor doors did not fit	KO	K 018 Resident rooms 1, 7, and 111 r properly. Due to wood door wa existing door seals did not provadequate smoke seal. A larger been adhered to these door fra providing a tight smoke seal. Resident room 103 the door lobeen taken apart, cleaned and The lockset was re-installed ar ensure a positive latch. All doors with this type of const have been re-inspected. These two issues will be added preventative maintenance prog a year for on-going compliance Responsible persons for correc on-going compliance: Paul Rud Environmental Director, and the	rpage the ride an seal has mes ckset has re-oiled, d tested to ruction I to our ram twice tion and lolph,	4/22/16

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES				1	0938-038
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 2004 BUILDING 2008 KITCHEI ADDITION				E SURVEY PLETED
		245489	B. WING			04/	19/2016
	PROVIDER OR SUPPLIER			14	REET ADDRESS, CITY, STATE, ZIP CODE 15 MADISON AVENUE ETROIT LAKES, MN 56501		3.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETIO DATE
K 018	Continued From p This deficient cond Environmental Dire	dition was verified by the	ΚO)18	Administrator Completion date: April 22, 2016		
K 022 SS=F	NFPA 101 LIFE SA	AFETY CODE STANDARD	К0)22			4/22/16
	readily visible sign way to reach exit is occupants. Doors, not a way of exit the an exit have a sign 7.10, 18.2.10.1, 19. This STANDARD Based on observate facility has failed to non-required doors not lead to the public NFPA 101 (00) see These deficient prall residents, staff confusion in locating the public way in the Findings include: On the facility tour 04/19/2016 observate exteriourt yard do not he	all be marked by approved, is in all cases where the exit or is not readily apparent to the passages or stairways that are lated are likely to be mistaken for in designating "No Exit". 2.2.10.1 is not met as evidenced by: ation and staff interview, the properly identify several is leading to the exterior that do like way in accordance with actions 7.10.1.7 and 7.10.8.1. actices could negatively affect and visitors, by causing an exit from the building to the event of an emergency. between 7:30 to 1:30 on rations and staff interview or doors that lead to the inner lave "NO EXIT" signs as the re locked, preventing access to			K022 All courtyard gates leading to publi are now left unlocked. Staff has be made aware of this change and the additional window alarms have bee added to the memory care unit to e resident safety. Responsible persons for correction on-going compliance: Paul Rudolp Environmental Director, and the Administrator Completion date: April 22, 2016	een e en ensure	
K 029 SS=E	Envoronmental Dir NFPA 101 LIFE SA	AFETY CODE STANDARD	K 0	29			4/22/16
- 3 -	fire-rated doors) or	I construction (with o hour an approved automatic fire m in accordance with 8.4.1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	T	0938-038
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	DING	E CONSTRUCTION 01 - 2004 BUILDING 2008 KITCHEN	(X3) DATE SURVEY COMPLETED	
		245489	B. WING			04/1	19/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME	:		1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 029	the approved autor option is used, the other spaces by sm doors. Doors are sfield-applied protect 48 inches from the permitted. 19.3.2 This STANDARD is Based on observarevealed that the faproper protection frareas located throu accordance with NI (2000 edition) section conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable, which conditions could in smoke and flames corridor and adjace untenable.	stects hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are 2.1 s not met as evidenced by: tions and staff interview, it was acility has failed to provide from 2 of several hazardous	K	029	K029 All penetrations in the Memory Carbasement storage room have been up using a UL approved type fire can steel cover has been fabricated a installed on the duct transfer, and a closer has been added to the entry An automatic door closer has been to the Oxygen storage room in the Memory Care Unit. Responsible persons for correction on-going compliance: Paul Rudolp Environmental Director, and the Administrator Completion date: April 22, 2016	n sealed aulking. and a door door. n added	
	memory care has n the requirements fo (Penetrations in wa no door closer).	m in the basement of the not been constructed to meet or hazardous storage. Ils, including a transfer duct, age room in the memory care oser.					
	This deficient condi Envoronmental Dire	ition was verified by the ector.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG 01 - 2004 Building 2008 Kitchen N	СОМ	E SURVEY PLETED
	PROVIDER OR SUPPLIER JEL NURSING HOME	245489	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501	04/19/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 062 SS=E	Required automatic continuously maintal condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on documer with staff, the facility and maintain the autocordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, 1 Water Based Fire F deficient practice dosprinkler system is fully operational in the negatively affect, 22 undetermined amount of the facility tour knowledge of the sprinkler heads.	tion was verified by the	K 06	K062 The sprinkler heads in resident r 101, 102 and 106 have paint ove them due to construction. Nova I Protection, Fargo ND, has been inspect the sprinkler heads and I ordered new replacement heads be installed by May 13, 2016. Periodic inspection of the sprinkl to ensure cleanliness will be add preventative maintenance progra Responsible persons for correcti on-going compliance: Paul Rudo Environmental Director, and the Administrator Completion date: May 13, 2016	erspray on Fire here to has . They will er heads ed to the am. on and	5/13/16

PRINTED: 05/10/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATÉ SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - 1963 MAIN BUILDING 245489 B. WING 04/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1415 MADISON AVENUE **EMMANUEL NURSING HOME DETROIT LAKES, MN 56501** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY Building 02 - 2004 Addition and 2008 Kitchen Addition THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey Emmanuel Nursing Home Building 02 - 2004 Addition and 2008 Kitchen Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Health Care Fire Inspections (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Electronically Signed 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 05/10/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1963 MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		245489	B, WING			04/	19/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME		*	1.	TREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of vertice to correct the deficition of the correct the actual, or provide the correct of the facility was insufficially was i	Division Pet, Suite 145 tate.mn.us m@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. pposed, completion date.	K	0000			

Facility ID: 00013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION (X3 G 02 - 1963 MAIN BUILDING	DATE SURVEY COMPLETED
		245489	B. WING		04/19/2016
	PROVIDER OR SUPPLIER UEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 000	automatic fire sprin with NFPA 13 Stand Sprinkler Systems fire alarm system the corridor smoke detection in all comaccordance with NFA Alarm Code" 1999 automatic fire detection in accordance fire Code and the single station smok rooms that annunci	pletely protected with an kler system in accordance dard for the Installation of 1999 edition. The facility has a nat includes 30-foot on center ection, with additional mon areas installed in FPA 72 "The National Fire edition. Hazardous areas have ctors that are on the fire alarm are with the Minnesota State 1997 and 2004 additions have e detection in the sleeping ates at the respective nurse's noce with the Minnesota State	K 000		
K 022 SS=E	The requirement at NOT MET as evide NFPA 101 LIFE SA Access to exits shareadily visible signs way to reach exit is occupants. Doors, Inot a way of exit that an exit have a sign 18.2.10.1, 19.2.10.1 This STANDARD is Based on observat facility has failed to non-required doors not lead to the publi NFPA 101 (00) sections.	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD If be marked by approved, in all cases where the exit or not readily apparent to the bassages or stairways that are at are likely to be mistaken for designating "No Exit". 7.10,	K 022	K022 All courtyard gates leading to public ware now left unlocked. Staff has been made aware of this change and the additional window alarms have been added to the memory care unit to ensure the additional window alarms have been added to the memory care unit to ensure the state of the memory care unit to ensure the state of the memory care unit to ensure the state of the memory care unit to ensure the state of the memory care unit to ensure the state of t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1963 MAIN BUILDING		(X3) DATE SURVEY COMPLETED
		245489	B. WING _		04/19/2016
	PROVIDER OR SUPPLIER	RECTION CATE STATE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION
K 022	confusion in locating the public way in the Findings include: On the facility tour In 04/19/2016 observative revealed the exterior court yard do not had court yard gates are the public way. This deficient practic Envoronmental Dirent NFPA 101 LIFE SA. Hazardous areas a with 8.4. The areas hour fire-rated barring door, without windo Doors shall be self-accordance with 7.2 protected by a spring with 9.7, 18.3.2.1, 1 This STANDARD is Based on observative revealed that the faproper protection from the second through the s	and visitors, by causing g an exit from the building to e event of an emergency. Detween 7:30 to 1:30 on ations and staff interview or doors that lead to the inner ave "NO EXIT" signs as the elocked, preventing access to ice was verified by the ector. FETY CODE STANDARD The protected in accordance shall be enclosed with a one er, with a 3/4 hour fire-rated ws (in accordance with 8.4). Closing or automatic closing in 2.1.8. Hazardous areas are askler system in accordance 8.3.5.1. Is not met as evidenced by: ions and staff interview, it was cility has failed to provide om 1 of several hazardous ghout the facility in FPA Life Safety Code 101		resident safety. Responsible persons for correct on-going compliance: Paul Rud Environmental Director, and the Administrator Completion date: April 22, 2016 K029 All penetrations in the Memory basement storage room have bup using a UL approved type find A steel cover has been fabricate	Care een sealed e caulking. ed and nd a door ntry door. een added the tion and olph,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1963 MAIN BUILDING			COMPLETED	
	245489		B. WING			04/19/2016	
NAME OF PROVIDER OR SUPPLIER EMMANUEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	IX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE
K 029	Findings include: On the facility tour load/19/2016 observative revealed the soiled care area next to ne properly.	between 7:30 to 1:30 on ations and staff interview utility room in the long term urses desk #2 does not latch	K	029	Completion date: April 22, 2016		7

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

PRINTED: 05/10/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 03 - BUILDING 3 245489 B. WING 04/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1415 MADISON AVENUE **EMMANUEL NURSING HOME DETROIT LAKES, MN 56501** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** Building 03 - 2014 Transitional Care Unit Addition THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey Emmanuel Nursing Home Building 03 - 2014 Transitional Care Unit Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101. Life Safety Code (LSC). Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Health Care Fire Inspections

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

FORM CMS-2567(02-99) Previous Versions Obsolete

05/06/2016

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.

Facility ID: 00013

CENTE	KS FOR MEDICARI	E & MEDICAID SERVICES				JIVID IVO.	0930-038	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 3			(X3) DATE SURVEY COMPLETED	
		245489	B. WING			04/	19/2016	
NAME OF PROVIDER OR SUPPLIER EMMANUEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE DETROIT LAKES, MN 56501		,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO	Division eet, Suite 145 1 state.mn.us n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:		000				
	to correct the defic 2. The actual, or pr 3. The name and/oresponsible for corr	oposed, completion date.						
	The Emmanuel Nu Transitional Care U 03). The Transition partial basement by	Init addition in 2014 (building hal Care Unit is a 1 story with uilding that was determined to construction and separated		27				
	automatic fire sprin with NFPA 13 Stand Sprinkler Systems fire alarm system the corridor smoke details.	apletely protected with an kler system in accordance dard for the Installation of 1999 edition. The facility has a nat includes 30-foot on center ection, with additional mon areas installed in					G.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2016 FORM APPROVED OMB NO. 0938-0391

			TIPLE CONSTRUCTION ING 03 - BUILDING 3	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245489	B. WING		04/	19/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIF 1415 MADISON AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 022	court yard do not hat court yard gates are the public way.	or doors that lead to the inner ave "NO EXIT" signs as the elocked preventing access to ce was verified by the	K 0	22		
						*



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 29, 2016

Ms. Janet Green, Administrator Emmanuel Nursing Home 1415 Madison Avenue Detroit Lakes, MN 56501

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5489025

Dear Ms. Green:

The above facility was surveyed on April 18, 2016 through April 21, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 after the

Emmanuel Nursing Home April 29, 2016 Page 2

statement, "This Rule 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 Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 05/23/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

AND BLAN OF CORRECTION (INDENTIFICATION NUMBER)		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00013	B. WING		04/2	1/2016
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE UE		
EMMAN	UEL NURSING HOME	DETROIT	LAKES, MN	56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber arule contain comply with any of tack of compliance.	nether a violation has been				
	result in the assess	ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/06/16 **Electronically Signed**

TITLE

STATE FORM 6899 08FG11 If continuation sheet 1 of 9

AND BLAN OF CORRECTION \ IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00013	B. WING		04/2	21/2016
	PROVIDER OR SUPPLIER UEL NURSING HOME	1415 MAD	DRESS, CITY, S DISON AVENI LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. Is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm. On April 18th, 19th, surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordethey will be completed. Minnesota Departmente State Licensing federal software. Ta assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of completed in the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of completed in the statement, evidence by." Follow are the Suggested Time period for Correction Cor	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health. 20th and 21st 2016, epartment's staff, visited the the following correction Please indicate in your prection that you have ers, and identify the date when ted. The health is documenting Correction Orders using ag numbers have been onta state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute in This Rule is not met as wing the surveyors findings Method of Correction and rection. TRD THE HEADING OF THE	2 000			
	FOURTH COLUMN "PROVIDER'S PLA					

Minnesota Department of Health

STATE FORM 6899 08FG11 If continuation sheet 2 of 9

AND BLAN OF CORRECTION INTERPRETATION NUMBER:					DATE SURVEY COMPLETED	
		00013	B. WING		04/2	21/2016
	PROVIDER OR SUPPLIER JEL NURSING HOME	1415 MAD	DRESS, CITY, S DISON AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	THERE IS NO REC		2 000			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			5/21/16
	by: Based on observati review, the facility fa directed by the indiv resident (R7) who re grooming.	ent is not met as evidenced on, interview and document ailed to provide assistance as vidualized care plan for 1 of 3 equired staff assistance for		corrected		
	had self care deficit and grooming due t osteoarthritis. The o legally blind and had	sed on 8/26/15, indicated R7 related to bathing, dressing o obesity, osteoporosis, and care plan identified R7 was d macular degeneration and o assist R7 with grooming, 19.				
	was noted to have was noted to have was noted to have was upper lip which extended onto her entire chin	on 4/19/16 at 10:49 a.m. R7 white, thick facial hair on her ended over her lip area and and cheek areas. The facial nately 1/4 inch or longer. At				

Minnesota Department of Health

STATE FORM 6899 08FG11 If continuation sheet 3 of 9

STATEMEN	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
		00040	B. WING		04/0	1/0010
		00013	B. WING		04/2	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EMMAN	JEL NURSING HOME		ISON AVEN LAKES, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	3:06 p.m. R7's facia	al hair remained the same.				
	was noted to be lay storybook on her recoarse facial hair or over her lip area and cheek areas. R7's 1/4 inch or longer. A herself out of her repropelling the wheek hands to go to the coarse the same. During observation was in the beauty s	on 4/20/16 at 7:14 a.m. R7 ing on her bed listening to a corder. R7 had white, thick, in her upper lip which extended d onto her entire chin and facial hair were approximately At 7:27 a.m. R7 wheeled from in the wheelchair, lichair with her feet and her dining room for breakfast. At all hair was observed to remain on 4/21/16 at 9:43 a.m. R7 hop getting her hair done by final white, thick, coarse facial				
	hair on her upper lip area and onto her e The facial hairs wer longer. After the be 2:17 p.m., R7 was o	nad white, thick, coarse facial owhich extended over her lip entire chin and cheek areas. The approximately 1/4 inch or auty shop appointment, at observed and the thick, white I the same on her lip, chin and				
	facial hair remained chin and cheek are had to shave often most bothersome. So not help her with sharied, the razor does bother with it." R7 is bothered her and ston my face." R7 staforward and put on face." R7 indicated	e a.m. the thick, white, long I present on R7's upper lip, a. R7 stated in the past she because her chin hair was the She indicated staff usually did aving and stated "they have a not work, so they don't indicated the facial hair rated "I wish I did not have it ated "I like to put my best face a smile, but I have hair on my dishe used to have her own was no longer safe for her to				

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use. R7 indicated she would like to have the

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AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING			
		00013	B. WING		04/2	21/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EMMAN	JEL NURSING HOME		ISON AVEN LAKES, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 565	Continued From pa	age 4	2 565			
	facial hair shaved o	off.				
	confirmed staff route for cares, picked he she had clean cloth used to have disposallowed to use them and stated "I do not that works." NA-A is with that much facial On 4/21/16 at 12:00 (DON) confirmed Findicated R7 had possistance with groexpectation of staff on a daily basis to be indicated if the raze expect staff to reponew razor and state be offering to shave assist R7 to get an stated she expecte as written and indicated razors to use within not working properly					
	revised on 11/15, in that care is planned	olicy titled, Care Plan /Kardex, ndicated staff was to ensure d to attain or maintain the nighest practicable physical, osocial well being.				
	The director of nurs review and revise p to ensuring the care	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual l. The director of nursing or				

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:					SURVEY PLETED	
		00013	B. WING		04/2	21/2016
FMMANUEL NURSING HOME 1415 MAD			DRESS, CITY, S DISON AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	designee could dev and develop a mon are providing care a of care.	ge 5 relop a system to educate staff itoring system to ensure staff as directed by the written plan R CORRECTION: Twenty-one	2 565			
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary good nutrition, grooming,	2 920			5/21/16
	by: Based on observati interview, the facility assistance for 1 of assistance with gro Findings include: R7's quarterly Mining 2/16/16, indicated F	ent is not met as evidenced on, interview and document y failed to provide shaving 3 residents (R7) who required oming. num Data Set (MDS) dated R7 had diagnoses which legal blindness, and macular		corrected		
	degeneration . The cognition and requipersonal hygiene, comparison of the cognition of the	MDS identified R7 had intact red extensive assistance for dressing, toileting, and bathing. sed on 8/26/15, indicated R7 related to bathing, dressing to obesity, osteoporosis, and care plan identified R7 was				

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AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00013	B. WING		04/2	21/2016
	PROVIDER OR SUPPLIER UEL NURSING HOME	1415 MAD	DRESS, CITY, S DISON AVENI LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	legally blind and had directed staff was to bathing and dressin. During observation was noted to have oupper lip which externorm on the entire chin hairs were approxing 3:06 p.m. R7's facial. During observation was noted to be lay storybook on her recoarse facial hair or over her lip area and cheek areas. R7's 1/4 inch or longer. A herself out of her repropelling the wheek hands to go to the office of the same. During observation was in the beauty sthe beautician, R7 hair on her upper lip area and onto her extended to shave often and cheek areas. On 4/21/16 at 11:42 facial hair remained chin and cheek areas. On 4/21/16 at 11:42 facial hair remained chin and cheek are had to shave often	d macular degeneration and assist R7 with grooming,	2 920			

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AND DUAN OF CODDECTION IN IDENTIFICATION NUMBER.		L` ´COM		(X3) DATE	SURVEY LETED	
		A. BUILDING:		00.00		
		00013	B. WING		04/2	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EMMAN	JEL NURSING HOME		ISON AVEN			
			LAKES, MN		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 7	2 920			
	not help her with sharied, the razor does bother with it." R7 is bothered her and ston my face." R7 staforward and put on face." R7 indicated razor but the razor use. R7 indicated sfacial hair shaved on 4/21/16 at 11:49	laving and stated "they have so not work, so they don't indicated the facial hair stated "I wish I did not have it lated "I like to put my best face a smile, but I have hair on my dishe used to have her own was no longer safe for her to she would like to have the ff.				
	for cares, picked he she had clean cloth used to have dispos allowed to use them and stated "I do not that works." NA-A ir	cinely assisted R7 with set up er clothes out and made sure les on. NA-A indicated R7 sable razors and she was not in, so she got an electric razor know if she got a new razor indicated that usually residents all hair should be shaved.				
	(DON) confirmed R indicated R7 had possistance with groexpectation of staff on a daily basis to be indicated if the razo expect staff to reponew razor and state be offering to shave assist R7 to get a n stated she expected as written and indic razors to use within not working properly					
	Standards, revised	olicy titled, Nursing Care on 11/15, indicated staff and /or assist all residents to				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00013	B. WING		04/2	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EMMAN	UEL NURSING HOME		ISON AVEN LAKES, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	achieve their higher dignified and courte assistance with or seresidents as necess well groomed. SUGGESTED MET The director of nurse all residents who reformed to daily living to assencessary treatment activities of daily living to designee, could condelivery of care; to services are implent ADLs are maintained.	st level of functioning, in a cous manner. Staff will provide supervision of shaving sary to keep them clean and THOD OF CORRECTION: sing or designee, could review quire assistance with activities ture they are receiving the inf/services to maintain all ing. The director of nursing or induct random audits of the ensure appropriate care and mented; to ensure all residents	2 920			

6899

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