Electronically Delivered August 16, 2019

Ms. Danielle Olson, Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

Subject: Emmanuel Nursing Home - IDR
CMS Certification Number (CCN) 245489
Project # S5489029

Dear Ms. Olson:

This is in response to your letter of May 31, 2019, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F697 483.25(k) Pain Management, issued pursuant to the survey event 4I2L11 completed on May 3, 2019.

The information presented with your letter, the CMS 2567 dated May 3, 2019 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of MDH staff have been carefully considered and the following determination has been made:

Tag ID Prefix # F697 S/S – (G) 42 CFR § 484.25(k) Pain Management: The facility must ensure that pain management is provided to residents that require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences.

Summary of the facility's reason for IDR of this tag:

The facility alleges the resident presented with increased pain without incident, that the symptoms the resident was exhibiting may have been symptoms of anxiety rather than symptoms of pain, the family had recently requested to hold the anxiety medication, and the facility asserts they had made several attempts to control the resident's pain.

Summary of facts:

The facility had identified, and contacted the physician, regarding the resident experiencing increasing pain symptoms on 4/28/19, and again on 4/30/19. On each of these dates pain medications were increased to relieve the resident's pain. On 4/30/19, the physician ordered morphine 2.5 mg (milligrams) every 6 hours while awake, and to continue morphine 2.5 mg every 2 hours as needed (PRN) to treat the resident's pain. The resident's care plan directed staff to offer non-pharmaceutical interventions prior to and in conjunction with, offering pain medication. The nursing assistant care sheet directed staff to check on the resident every 2 hours.

On 4/30/19, the surveyor observed the resident exhibiting what appeared to be non-verbal indicators of pain including the resident moving legs up and down, furrowed brow, and a clenched jaw. The resident's family was present during the observation and identified this as severe pain for the resident. The family member also identified the resident had recently experienced a change in condition which included experiencing a lot of pain.

On 5/1/19, the medication administration record indicated a dose of 2.5 mg of morphine was administered at 3:00 a.m. According to the nursing notes, staff had last documented seeing the resident asleep at 5:00 a.m. On 5/1/19, during continuous observation from 7:00 a.m. to 9:20 a.m., the surveyor observed the resident experiencing what appeared to be symptoms of severe pain including; moans that could be heard from the hall, brows furrowed, jaw clenched tight, tears running down the corner of her eyes, heavy breathing, and moaning and whimpering that increased with movement. During this observation staff, including licensed nurses, were observed near by in the hall. No staff responded to the resident's verbalizations, or came into the resident's room to check on her, until a nursing assistant came in the room to assist the resident to the toilet at 7:54 a.m. Although the symptoms that appeared to be pain continued, and increased in severity, the nursing assistant did not offer any non-pharmaceutical interventions, nor did the aide inform a nurse of the symptoms the resident was exhibiting. The symptoms continued as described above, throughout the continuous observation even as staff assisted the resident with care. At 9:20 a.m., a nurse entered the room and administered the resident's scheduled morphine. Although the resident had an order for morphine 2.5 mg as needed, the resident did not receive any pain medication for a period of over 6 hours. The nursing assistant did not report symptoms the resident was exhibiting while providing care, nor did a nurse enter the resident's room to assess whether the symptoms the resident was exhibiting were related to pain, or to offer or provide the PRN medication in an effort to reduce the symptoms that were indicative of severe pain.

Summary of findings:
This is a valid deficiency at this tag issued at the correct scope and severity of (G).

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Kathy Lucas, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 320-223-7343 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Gail Anderson, Fergus Falls District Office Unit Supervisor
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4I2L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00013

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245489**

2.STATE VENDOR OR MEDICAID NO.
(L2) **726040700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EMMANUEL NURSING HOME**
(L4) **1415 MADISON AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/19/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **102** (L18)
13.Total Certified Beds **102** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	102			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jonathon Anderson, HFE - NE II 07/02/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/02/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/13/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 2, 2019
CMS Certification Number (CCN): 245489

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

Dear Administrator:

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 June 4, 2019 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 2, 2019

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

RE: Project Number S5489029

Dear Administrator:

On May 25, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 22, 2019.

Also on May 25, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy(ies):

- Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on May 3, 2019. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 19, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 24, 2019 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 May 3, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 4, 2019. We have determined, based on our visit, that your facility has corrected as of June 4, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2019 be rescinded as of June 4, 2019. (42 CFR 488.417 (b))

In our letter of May 25, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 22, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 4,

2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded however, this does not apply to or affect any previously imposed NATCEP loss.

In addition, this Department recommended to the CMS Region V Office the following the remedy:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4I2L

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(L1) **245489**

2.STATE VENDOR OR MEDICAID NO.
(L2) **726040700**

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(L3) **EMMANUEL NURSING HOME**
(L4) **1415 MADISON AVENUE**
(L5) **DETROIT LAKES, MN** (L6) **56501**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/03/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	102			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Jana Wegner, HFE - NE II 06/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 06/11/2019 (L20)

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19. DETERMINATION OF ELIGIBILITY
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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 25, 2019

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

RE: Project Number S5489029

Dear Administrator:

On May 3, 2019, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 22, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 22, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 22, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits

approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 22, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Emmanuel Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 22, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” 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
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 3, 2019 (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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	05/03/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/29/19 through 5/3/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/29/19 - 5/3/19, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		6/4/19

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

Electronically Signed | 05/31/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	05/03/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 resident (R33) who utilized a urinary catheter.	F 550	F550 Resident Rights/Exercise of Rights Corrective action to resident found to be affected: Resident 33□s Catheter bag	

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F 550	Continued From page 2 Findings include: R33's quarterly Minimum Data Set (MDS) dated 2/14/19, indicated R33 had diagnoses of heart failure, Diabetes Mellitus and obstructive uropathy (condition in which the flow of urine is blocked). The MDS identified R33 was cognitively intact and required total assist with transfers, and extensive assist with bed mobility, dressing, toilet use and personal hygiene. The MDS further identified R33 had an indwelling urinary catheter. R33's Care Area Assessments (CAA) dated 2/14/19, indicated R33 was at risk for urinary retention due to altered mobility and benign prostatic hypertrophy (BPH), and had a suprapubic catheter. The CAA identified R33 required extensive assistance with toileting, mobility, catheter care and adjustment of clothing. R33's care plan last revised 4/26/19, indicated R33 had a suprapubic catheter and required extensive assist with toileting. On 4/30/19, at 11:03 a.m. R33 was lying in bed with the head of the bed up and multiple newspapers surrounding him. R33's catheter tubing was observed draining into a bag, which was inside a dark blue bag attached to R33's bed. R33 stated he has had a suprapubic catheter for some time, and did not like having the catheter or tubing. R33 indicated keeping the catheter drainage bag in the covered bag holder was important to him as he would not want others to see his urine. On 5/1/19, at 7:00 a.m. during an observation from R33's doorway, which was open 4-6 inches,	F 550	was covered immediately to promote dignity. How the facility identified other residents potential to be affected: House audit conducted to ensure no others were affected. Measures put in place to ensure it will not recur: Order placed in the Treatment record to remind staff that Catheter bags are to be checked every shift to ensure they are covered. All staff education on covering catheter bags to promote dignity. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors/Director of Nursing Date of completion: 6/4/2019	

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F 550	Continued From page 3	F 550		

R33 was lying in bed with eyes closed. R33's bed frame was approximately three feet up from the floor, and a catheter cover bag was observed attached to the bed frame hanging down, on the door side of his bed. Approximately four inches down from the catheter cover was a catheter drainage bag which also hung from the bed frame and faced the door. The catheter drainage bag had a white backing, which faced the bed, and a clear front, which faced the door. The catheter bag was observed to be approximately a fifth full of yellow urine.

At 7:24 a.m. on 5/1/19, nursing assistants (NA)-O and NA-P entered R33's room and R33's urinary catheter drainage bag and urine remained visible from the doorway. NA-O shut R33's door and the NAs assisted R33 to reposition in bed. NA-O then placed stockings on R33's legs and then placed blue gripper socks on R33's feet. NA-P and NA-O left R33's room and left R33's door approximately half open. Neither NA-P nor NA-O were observed to offer, or assist, R33 to place the urinary drainage bag into the bag cover. R33's drainage bag with urine in it was visible from the doorway. At 8:08 a.m. R33's catheter drainage bag and urine remained in view from R33's doorway. At 8:32 a.m. no change in position of R33's catheter drainage bag, as an unidentified staff member pushed another resident past R33's open door.

At 8:46 a.m. on 5/1/19, R33 remained in bed as NA-O entered the room carrying a meal tray. At 8:47 a.m. NA-P entered R33's room and closed the door. The NAs assisted R33 to reposition in bed and NA-P left the room. NA-O assisted R33 with breakfast meal set up on the over the bed table. R33 asked for a soda and ice. At that time

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F 550	Continued From page 4	F 550		

NA-O left the room. At 8:55 a.m. NA-O returned to R33's room with a small pitcher of ice and cola, walked up to R33, past the drainage bag, and placed items on the table. R33 then asked for more peanut butter and NA-O left R33's room again. At 8:58 a.m. NA-O entered R33's room again, dropped off the items and left R33's room, leaving the door to the hallway open. R33's urinary drainage bag remained in view from the doorway.

At 9:11 a.m. on 5/1/19, R33 remained in bed and the urine filled urinary drainage bag remained visible from the doorway. At that time, an unidentified staff member pushed an unidentified resident in a wheelchair to R33's open doorway and the unidentified resident knocked on R33's doorframe. The staff member left the resident in the wheelchair directly in front of R33's door. The resident handed the staff member two newspapers, and the staff member entered R33's room, dropped off the newspapers and left R33's room.

On 5/1/19 at 9:29 a.m., licensed practical nurse (LPN)-E entered R33's room with a medication cart and parked the cart near R33's bed. LPN-E then left R33's room and returned a minute later with a glass of half orange juice and half water. LPN-E then mixed a powder substance into the juice and approached R33's bed. LPN-E stood on the door side of R33's bed, and her right scrub pant leg pressed against R33's urinary drainage bag, which was in the same position. From 9:32 a.m. until 9:49 a.m. LPN-E remained in R33's room and administered medications which included a nebulized medication. At 9:49 a.m. LPN-E stooped over near R33's urinary drainage bag and picked up a piece of white material off of

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F 550	Continued From page 5	F 550		

the floor and placed it in R33's garbage. At 9:50 a.m. LPN-E left R33's room and was not observed to offer or assist R33 in placing the urinary catheter bag into the covered bag.

On 5/1/19, at 11:15 a.m. NA-O stated R33 required total assist with transfers, and extensive assistance for bed mobility, dressing, toilet use and personal hygiene. NA-O indicated R33 had a suprapubic catheter which drained into a drainage bag. At that time, NA-O confirmed R33's urinary drainage bag was hanging next to the drainage bag cover and was visible from the doorway. NA-O stated R33 was very particular about his routine and appearance.

On 5/1/19, at 1:18 p.m. LPN-E stated R33 had a suprapubic catheter with a urine collection bag. At that time, LPN-E confirmed the urinary drainage bag was visible from the doorway and should have been in the covered bag. LPN-E stated R33 was a proud man and liked to look proper, and added "if it were my parents, I would want them to have it [drainage bag] in a privacy [covered] bag."

On 5/2/19, at 10:16 a.m. registered nurse (RN)-A stated R33 had a suprapubic catheter and the usual process staff followed was to place the catheter drainage bag into a catheter bag cover for dignity.

On 5/2/19, at 1:54 p.m. RN clinical manager (CM)-A stated every resident with a catheter in the facility should have their urinary catheter drainage bag in a covered bag for dignity reasons.

On 5/3/19, at 9:35 a.m. the director of nursing (DON) stated the facility had catheter drainage

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F 550	Continued From page 6 bag covers and the goal was for staff to place the catheter drainage bag into the covered bags for privacy. Review of the facility's 11/13 policy, Catheter (Urinary Drainage) Bag Holder, indicated the policy was to restore the dignity of catheterized residents by concealing urinary drainage bags from public view. The policy directed staff to place the drainage bags in a bag holder when the resident was in a wheelchair, recliner, geri-chair, or up ambulating to restore the dignity of the resident. The policy further indicated when a resident was in bed, the drainage bag did not need to be in the drainage bag holder, but staff must turn the drainage bag so the urine was not visible to public view.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		6/4/19

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F 609	Continued From page 7 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to recognize and ensure an allegation of potential neglect was reported to the State Agency (SA) for 1 of 3 residents (R64) whose allegations were reviewed. Findings include: R64's 30-day Prospective Payment System (PPS) Minimum Data Set (MDS) assessment dated 4/2/19, indicated R64 had diagnoses including heart failure, Diabetes Mellitus and difficulty in walking. The MDS identified R64 had moderate cognitive impairment and required extensive assistance for transfers, dressing, toilet use and personal hygiene. The MDS further indicated R64 had no behaviors or rejection of care, had a functional limitation in range of motion on one side lower extremity, and did not walk. During an interview on 4/29/19, at 2:17 p.m. R64 told the surveyor, on 4/24/19, at 11:00 p.m. nursing assistant (NA)-A assisted R64 to the toilet and R64 was left there until approximately 1:30 a.m. on 4/25/19. R64 stated she was still "mad" it happened. R64 stated after finishing using the toilet that night, she'd used the bathroom call light	F 609	F609 Reporting of Alleged Violations Corrective action to resident found to be affected: R 64 was assisted immediately and call button was fixed to prevent recurrence. R 64 was interviewed and expressed no further concerns regarding the allegation. How the facility identified other residents potential to be affected: House audit by resident interview done to assure no other incidents had occurred that may be reportable. Measures put in place to ensure it will not recur: Call light report will be run weekly by IT to ensure no other resident has a call light battery that is running low. The administrator, DON, and social services will review procedures regarding the internal process of reporting and investigating the process of abuse or maltreatment. The administrator, DON, ADON, nurse managers, and social service will review resident abuse and reporting training. The DON or designee	

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F 609	Continued From page 8 to alert staff of the need for assistance, but no one came. R64 stated after she'd waited for some time, had tried to stand up twice by pulling on the nearby EZ-Stand's (mechanical transfer device) arms, but was worried about falling so stopped. R64 stated she'd yelled for help, but NA-A had shut the room's door for privacy. R64 stated NA-A returned to the bathroom at approximately 1:30 a.m. and NA-A indicated R64's call light was not on. R64 stated on 4/25/19, staff came and fixed the bathroom call light. R64's medical record was reviewed and lacked any evidence of the allegation of potential neglect on 4/24/19, into 4/25/19. On 5/2/19, at 9:40 a.m. NA-B acknowledged having worked on 4/25/19, and during the shift to shift report, prior to the start of the shift, it had been reported R64 was left on the toilet for about two hours during the night shift. NA-B stated on 4/25/19 during the day shift, R64 had also reported being left on the toilet during the night by NA-A for over two hours. On 5/2/19, at 1:33 p.m. registered nurse clinical manager (RNC)-A stated she was updated on R64's allegation of potential neglect from an email from licensed practical nurse (LPN)-A on 4/25/19. RNC-A stated the allegation was reviewed on 4/25/19, at the unit's morning meeting, which included the director of nursing (DON) and administrator. RNC-A stated since there was no ill intent, and R64 was not harmed, the facility did not feel the allegation needed to be reported to the SA. Review of an email dated 4/25/19, at 1:42 a.m.	F 609	to educate staff. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Administrator, RN Managers/Supervisors, Social Services, Director of Nursing. Date of completion: 6/4/2019	

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F 609	Continued From page 9	F 609		

from LPN-A to RNC-A indicated R64 had been placed on the toilet by NA-A. The email indicated NA-A had not seen R64's call light go off and assumed another staff member had gotten R64 off of the toilet. The email further indicated, two to two and a half hours later, NA-A was doing a check on R64 and discovered R64 still on the toilet. The email identified R64's bathroom call light button was not working. The email further identified R64 stated she was banging and yelling, but no one had heard anything even when staff had been back and forth down the hall on multiple occasions.

On 5/2/19, at 2:23 p.m. during a phone interview, NA-A acknowledged having assisted R64 to the bathroom on 4/24/19 at 11:00 p.m. NA-A verified R64 was not noticed to still be on the toilet until 1:27 a.m. on 4/25/19. NA-A stated while walking in R64's hallway, she'd noticed R64's door was closed, and since R64 always slept with the door open, NA-A entered to check on R64. When R64 was still in the bathroom, NA-A had stated "you're still on that thing?" NA-A stated she'd determined R64's call light in the bathroom was not operating as she'd checked it after getting R64 back to bed safely. NA-A stated R64 was upset at the time so she'd updated LPN-A immediately after R64 was in bed and safe.

On 5/2/19, at 2:35 p.m. LPN-A was called, however a return call was not received.

On 5/3/19, at 1:52 p.m. the DON stated services provided by the facility included transferring residents on and off the toilet, assisting residents with toileting needs and answering call lights. The DON stated the usual facility practice was to report any allegations of abuse immediately, and

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F 609	Continued From page 10 other incidents where a resident was hurt, or if there was an intent to harm or neglect a resident then staff would complete an internal investigation and decide whether or not to report the incident to the SA. On 5/3/19, at 2:03 p.m. the administrator stated she'd updated on R64's allegation the morning of 4/25/19. The administrator stated R64's allegation was discussed with the interdisciplinary team (IDT) and they'd felt it was not reportable to the SA due to no ill intent from staff, no harm to R64, and added "it just seemed like a strange set of circumstances." Review of facility's undated policy, Abuse Prevention Plan for Minnesota Skilled Facilities, indicated the facility required all suspected maltreatment/mistreatment be reported to the SA pursuant to the policy and procedure. The policy indicated the facility professional who received the report of suspected maltreatment/mistreatment was then responsible for immediately reporting the maltreatment/mistreatment to the administrator, or designee and the SA. The policy further identified the administrator, or designee was responsible for ensuring that an internal investigation was completed and the results were reported to the SA.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		6/4/19

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F 610	Continued From page 11 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of potential neglect for 1 of 3 residents (R64) whose allegations were reviewed. Findings include: R64's 30-day Prospective Payment System (PPS) Minimum Data Set (MDS) assessment dated 4/2/19, indicated R64 had diagnoses including heart failure, Diabetes Mellitus and difficulty in walking. The MDS identified R64 had moderate cognitive impairment and required extensive assistance for transfers, dressing, toilet use and personal hygiene. The MDS further indicated R64 had no behaviors or rejection of care, had a functional limitation in range of motion on one side lower extremity, and did not walk. R64's care plan, last reviewed 4/1/19, indicated R64 was a vulnerable adult due to nursing home placement and current diagnosis. The care plan listed several interventions which included: notify registered nurse (RN) supervisor, director of	F 610	F 610 Investigate/Prevent/Correct Alleged Violation Corrective action to resident found to be affected: The alleged violation was investigated thoroughly. F/U will staff member with education and counseling given. How the facility identified other residents potential to be affected: House audit done to assure no other incidents had occurred that may be reportable or if there are concerns that proper follow up conducted. Measures put in place to ensure it will not recur: The DON and social services reviewed procedures regarding the internal process of investigating and made changes to internal investigation process. Education on the process will be done by the DON or designee. Updated Internal investigation form made to assure thorough investigation is conducted going	

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	245489	A. BUILDING _____ B. WING _____	05/03/2019

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

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nursing (DON), administrator and/or social service of any suspected maltreatment.

During an interview on 4/29/19, at 2:17 p.m. R64 told the surveyor, on 4/24/19, at 11:00 p.m. nursing assistant (NA)-A assisted R64 to the toilet and R64 was left there until approximately 1:30 a.m. on 4/25/19. R64 stated she was still "mad" it happened. R64 stated after finishing using the toilet that night, she'd used the bathroom call light to alert staff of the need for assistance, but no one came. R64 stated after she'd waited for some time, had tried to stand up twice by pulling on the nearby EZ-Stand's (mechanical transfer device) arms, but was worried about falling so stopped. R64 stated she'd yelled for help, but NA-A had shut the room's door for privacy. R64 stated NA-A returned to the bathroom at approximately 1:30 a.m. and NA-A indicated R64's call light was not on. R64 stated on 4/25/19, staff came and fixed the bathroom call light.

R64's medical record was reviewed and lacked any evidence of the allegation of potential neglect on 4/24/19, into 4/25/19.

R64's incident reports were requested for April 2019, however none were provided.

A review of the facility's vulnerable adult reports from 2/1/19 to 5/1/19, revealed no information regarding R64.

On 5/2/19, at 1:33 p.m. registered nurse clinical manager (RNC)-A stated she was updated on R64's allegation of potential neglect from an email from licensed practical nurse (LPN)-A on 4/25/19. RNC-A indicated she had not interviewed

forward.

How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings.

Responsible Persons: Administrator, RN Managers/Supervisors, Director of Nursing Social Services.

Date of completion: 6/4/2019

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the staff who had worked on R64's unit that night, as LPN-A had talked with them that night. RNC-A stated the morning of 4/25/19, the discharge specialist (DS)-A spoke with R64 regarding the allegation, and RNC-A had set out some informal education for staff to review and sign. RNC-A further stated she was unaware whether DS-A had interviewed other residents on the unit, but verified she (RNC-A) had not investigated the staffing pattern on the night of the allegation, nor had they investigated how R64's call light had malfunctioned.

Review of an email dated 4/25/19, at 1:42 a.m. from LPN-A to RNC-A indicated R64 had been placed on the toilet by NA-A. The email indicated NA-A had not seen R64's call light go off and assumed another staff member had gotten R64 off of the toilet. The email further indicated, two to two and a half hours later, NA-A was doing a check on R64 and discovered R64 still on the toilet. The email identified R64's bathroom call light button was not working. The email further identified R64 stated she was banging and yelling, but no one had heard anything even when staff had been back and forth down the hall on multiple occasions. However, the email lacked investigation or interviews regarding the allegation.

On 5/2/19, at 2:23 p.m. during a phone interview, NA-A acknowledged having assisted R64 to the bathroom on 4/24/19 at 11:00 p.m. NA-A verified R64 was not noticed to still be on the toilet until 1:27 a.m. on 4/25/19. NA-A stated while walking in R64's hallway, she'd noticed R64's door was closed, and since R64 always slept with the door open, NA-A entered to check on R64. When R64 was still in the bathroom, NA-A had stated "you're

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still on that thing?" NA-A stated she'd determined R64's call light in the bathroom was not operating as she'd checked it after getting R64 back to bed safely. NA-A stated R64 was upset at the time so she'd updated LPN-A immediately after R64 was in bed and safe. NA-A stated the morning after the incident, she'd waited for a phone call from staff to be interviewed, but no one ever called or interviewed her. NA-A stated she had no knowledge of any education provided to staff after R64's incident.

Review of informal education provided by RNC-A, dated 5/25/19 [4/25/19], indicated "Reminder: If you help someone onto the toilet please check to ensure they have been helped back off the toilet; please do not assume someone else has done it because you haven't seen the light go off. Call light may not be working or they could have fallen, etc."

On 5/2/19, at 2:35 p.m. LPN-A was called, however a return call was not received.

On 5/2/19, at 2:43 p.m. DS-A provided documentation of an interview with R64 from 4/25/19, DS-A stated she'd asked random residents on R64's unit how their stay was going, and if they had any concerns. DS-A stated she did not ask residents any specific questions regarding R64's allegation nor had they checked the operating status of any other call lights on R64's unit.

Review of DS-A's interview notes from conversation with R64 dated 4/25/19, confirmed R64's allegation and indicated R64 "was very upset but had the night/morning to calm down."

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On 5/2/19, at 3:33 p.m. maintenance technician (MT)-A stated he had received a work order for R64's bathroom call light on 4/25/19. MT-A stated when he reviewed R64's bathroom call light, he could not find anything wrong with it. MT-A stated he did not, and was not, asked to review any other call lights on R64's unit that day.

On 5/3/19, at 1:52 p.m. the DON stated services provided by the facility included transferring residents on and off the toilet, assisting residents with toileting needs and answering call lights. The DON stated the usual facility practice was to report any allegations of abuse immediately, and other incidents where a resident was hurt, or if there was an intent to harm or neglect a resident then staff would complete an internal investigation and decide whether or not to report the incident to the SA. The DON indicated she was aware of R64's allegation and stated staff had spoken with R64 and an internal investigation was completed. However, the DON did not provide any further information regarding R64's internal investigation.

On 5/3/19, at 2:03 p.m. the administrator stated she'd updated on R64's allegation the morning of 4/25/19. The administrator stated R64's allegation was discussed with the interdisciplinary team (IDT) and they'd felt it was not reportable to the SA due to no ill intent from staff, no harm to R64, and added "it just seemed like a strange set of circumstances."

Review of facility's undated policy, Abuse Prevention Plan for Minnesota Skilled Facilities, indicated the facility required all suspected maltreatment/mistreatment be reported to the SA pursuant to the policy and procedure. The policy

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F 610	Continued From page 16 indicated the facility professional who received the report of suspected maltreatment/mistreatment was then responsible for immediately reporting the maltreatment/mistreatment to the administrator, or designee and the SA. The policy further identified the administrator, or designee was responsible for ensuring that an internal investigation was completed and the results were reported to the SA.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide ongoing monitoring to identify a weight gain and increase in edema for 1 of 1 resident (R243) who was diagnosed with edema and utilized prescribed diuretics. Findings include: R243's admission Minimum Data Set (MDS) assessment indicated R243 had severe cognitive impairment and diagnoses that included; fluid overload, edema, aortic valve stenosis, cerebral vascular accident, and anemia. In addition, the	F 684	F684 Quality of Care Corrective action to resident found to be affected: Assessment done on R 243 by Erin Volden, PA on 4/29/19 weight/edema was reviewed with no concerns or changes in treatment at that time. How the facility identified other residents potential to be affected: House audit done to assure no other residents were affected. Measures put in place to ensure it will not	6/4/19

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F 684	Continued From page 17 MDS indicated R243 required extensive assistance from 1 staff with bed mobility, transfers, dressing, toileting and personal hygiene. R243's admission care plan dated 4/20/19, addressed various areas including self care deficits with activities of daily living (ADL)s and required assistance with dressing, bathing, bed mobility, and personal hygiene, and instructed staff to inspect skin with bathing and cares and report any changes or concerns to nursing staff. The care plan did not address ongoing assessment and monitoring for R243's edema, weight, or the use of diuretics. A review of R243's daily weights revealed an admission weight of 153 pounds on 4/20/19, and the following: - 4/21/19, 151.8 pounds - 4/23/19, 150.0 pounds - 4/24/19 153.0 pounds - 4/25/19 151.2 pounds - 4/26/19 - no weight recorded - 4/17/19 154.0 pounds - 4/28/19 160.0 pounds - 4/29/19 158.0 pounds - 4/30/19 160.0 pounds (10 pound increase in 1 week) - 5/1/19 160.2 pounds On 4/29/19, at 2:10 p.m. R243's bilateral feet and ankles were observed to appear swollen. R243 was observed to be wearing black compression stockings that were indented and cutting into the front and sides of the ankle area. On 5/1/19, at 7:18 a.m. R243 was observed in her room, walking out of the bathroom towards	F 684	recur: Education given to all staff. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors, Director of Nursing. Date of completion: 6/4/2019	

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F 684	Continued From page 18	F 684		

her bed per self with her walker. R243 was barefoot and her feet, ankles and lower legs were observed to be very swollen with 2-3+ pedal edema noted. R243 stated she wore compression socks to the knee during the day, and elevated her feet on pillows at night. R243 stated her feet were still very swollen, and stated the swelling was currently worse than normal. R243 stated she needed staff to help get the compression socks on because of the swelling, and verbalized it hurt when staff put the compression socks on. R243 also stated she would be seeing the doctor on rounds "tomorrow" and she hoped he could help with the edema in her feet and legs.

On 5/1/19, at 7:33 a.m. licensed practical nurse (LPN)-B verified the doctor would be seeing R243 the following day.

On 5/1/19, at 8:14 a.m. R243 was seated in the dining room at a table feeding herself. R243 was heard reporting to a staff person, "My legs are so swollen this morning." The staff responded, "Well hang in there."

On 5/1/19, at 8:25 a.m. a therapy staff was observed assisting R243 down the hall in her wheel chair. R243 was noted to be wearing the black knee high compression socks.

On 5/1/19, at 8:46 a.m. nursing assistant (NA)-B stated R243 needed help with dressing and bathing and stated she used compression socks for edema. In addition, NA-B stated the care plan and Kardex included interventions to monitor for worsening edema and weight gain. NA-B stated they weigh R243 consistently at the same time each day before breakfast. NA-B stated if there

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was anything unusual with a resident's weight, or if it fluctuated, they would reweigh the resident to verify whether the weight was accurate. NA-B stated they write the weight on the clip board and report to the nurse who documents it.

On 5/2/19, at 9:32 a.m. R243 was seated in a recliner chair in her room. R243 stated, "My legs are so cold and they get so swollen."

On 5/2/19, at 9:44 a.m. LPN-B stated if someone was on a daily weight monitoring, nursing would notify the provider if there was a significant weight change. LPN-B verified there were no progress notes to indicate R243's medical provider had been notified of her weight gain. LPN-B stated she had reported the weight increase to the supervisor around 4/27/19, but verified there was no documentation to indicate this. LPN-B stated if the provider had been updated, there should have been a progress note.

On 5/2/19, at 9:51 a.m. registered nurse (RN)-A stated the process for residents on daily weight monitoring would be to notify the provider of a weight gain of 3 pounds or greater in a day, or 5 pounds or greater in a week. RN-A stated she had not been notified of a weight increase for R243. RN-A stated she reviewed weights weekly, but would expect residents requiring daily weight monitoring to have their weights monitored daily. RN-A stated R243 was seen in house on 4/22/19 and her weight had been stable at that time. RN-A reviewed R243's daily weights and stated she would have expected the resident's medical provider to be updated regarding the weight gain. RN-A verified the medical record lacked any documentation of the medical provider having been notified. Further, RN-A stated the medical

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F 684	Continued From page 20 provider should have been updated with R243's weight gain on Monday and verified it had not been done. On 5/2/19, at 11:18 a.m. the director of nursing (DON) stated she would expect monitoring and interventions to be in place for someone with edema, on a diuretic, and daily weight monitoring. The DON stated she would expect the medical provider to be notified if there was a weight gain of 3 pounds or greater in a day, or 5 pounds or greater in a week. A review of the Nurse Practitioner (NP) visit notes from 4/29/19 and 5/2/19, revealed that although the NP had reviewed the resident's respiratory status, and edema, there was no documentation to verify the NP was aware of the resident's weight gain. A review of the facility's 2/2019 policy, Measuring the weight and height of the resident, revealed staff were to report any significant weight loss/weight gain to the Nursing Supervisor.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or	F 685		6/4/19

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F 685	Continued From page 21 the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident's (R55) had eye glassed in good working order. Findings include: R55's admission minimum data set (MDS) assessment dated 3/7/19, identified R55 had severe cognitive impairment and diagnoses including: dementia, a psychotic disorder and muscle weakness. The MDS indicated R55 was independent with bed mobility and eating, required supervision with walking, transfer and locomotion on and off of unit, and required extensive assistance with dressing toileting and personal hygiene. R55's care plan dated 3/7/19, directed staff to ensure R55 wore glasses which are clean, free from scratches, and in good repair. Staff were to report any damage to the nurse and family. An admission note dated 3/1/19 identified R55 wore glasses. On 4/29/19, at 3:13 p.m. R55 was observed seated at a table in the common area by the television. R55 was not wearing eye glasses. On 4/30/19, at 10:06 a.m. family member (FM)-F stated R55 had glasses but rarely wore them. FM-F acknowledged having to ask the nurse to find the glasses when family visits.	F 685	F685 Treatment/Devices to Maintain Hearing/Vision Corrective action to resident found to be affected: R 55□s Glasses were repaired to working order and being offered to resident. How the facility identified other residents potential to be affected: House Audit conducted to ensure no other residents were affected. Measures put in place to ensure it will not recur: Education provided to staff. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors, Director of Nursing, Social Services. Date of completion: 6/4/2019	

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On 5/1/19, at 7:07 a.m. and 7:17 a.m., R55 was observed seated in his room in a reclining chair watching television. R55 was not wearing glasses.

On 5/1/19, at 8:33 a.m. nursing assistant (NA)-Q delivered R55's breakfast tray to his room. NA-Q was observed to provide verbal cues and physical assistance to R55 with eating his breakfast. R55 was not wearing his glasses.

On 5/1/19, at 11:31 a.m. NA-Q verified R55 was dependent on staff for most adls.

On 5/2/19, at 1:58 p.m. NA-J stated R55 had glasses but was not sure whether he wore them at all times.

On 5/2/19, at 2:00 p.m. NA-K stated she did not believe R55 had glasses but would check the Kardex to be sure. With review of the Kardex NA-K verified R55 had glasses however, added the glasses had not been given to R55 that day because he went back to bed.

On 5/2/19, at 2:04 p.m. licensed practical nurse (LPN)-D stated, "I can't remember if he wears glasses or not. I know he hasn't recently." With review of R55's Kardex LPN-D verified the use of eye glasses was listed. LPN-D identified the glasses may be kept on the nurse's cart now because of R55 taking them off and leaving them places.

On 5/2/19, at 2:05 p.m. NA-J identified R55 had glasses in his closet which he wore at one time but no longer does.

On 5/2/19, at 2:12 p.m. LPN-C identified R55 no

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 685	Continued From page 23 longer wore glasses and stated they were stored in the medication cart. On 5/3/19, at 10:02 a.m. R55 was seated in a reclining chair in the common area of the facility. R55's feet were elevated on the foot rest and his eyes were closed. R55 was not wearing his glasses. On 5/3/19, at 10:03 a.m. registered nurse (RN)-E stated some resident items were stored in the medication cart. RN-E looked in the cart and found R55's eye glasses. RN-E stated, "[R55] is up now and should have his glasses on." RN-E stated the nursing assistants usually come to the cart to get the residents' hearing aids or glasses. RN-E then looked at R55's glasses and stated they were in a bit of disrepair adding, "I don't know if he has been wearing them." RN-E acknowledged she had forgotten about R55's eye glasses but said they should be followed up on with the nurse manager. On 5/3/19, the registered nurse clinical manager was not available for interview. On 5/3/19, at 12:58 p.m. the director of nursing (DON) identified the usual facility practice when items such as eye glasses are in need of repair is to notify the family and set up appointments if wanted and if necessary. A policy for eye glass use was requested, but not provided.	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		6/4/19

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	245489	A. BUILDING _____ B. WING _____	05/03/2019

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F 688	Continued From page 24 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to routinely provide range of motion services according to therapy recommendations to maintain function for 2 of 3 residents (R64, R86) reviewed for range of motion (ROM). Findings include: R64's 30-day Prospective Payment System (PPS) Minimum Data Set (MDS) assessment dated 4/2/19, indicated R64 had diagnoses of heart failure, Diabetes Mellitus and difficulty in walking. The MDS identified R64 had moderate cognitive impairment and required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS further indicated R64 had no behaviors or rejection of care, had a functional limitation in range of motion on one side lower extremity, did not walk, and	F 688	F688 Increase/Prevent Decrease in ROM/Mobility Corrective action to resident found to be affected: Restorative programs for R 64 and R 86 were entered and initiated. How the facility identified other residents potential to be affected: House audit done to assure no other residents were affected. Measures put in place to ensure it will not recur: Education given to staff. Changes to therapy forms so that the nurse entering the program must sign off on the form to assure it is entered. How the facility will monitor its performance to ensure solutions are	

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F 688	Continued From page 25 was receiving physical therapy (PT) and occupational therapy (OT). R64's Care Area Assessment (CAA) dated 3/8/19, indicated R64 had diagnoses of right below the knee amputation (BKA), Diabetes Mellitus and peripheral arterial disease (PAD). The CAA identified R64 required extensive assist for bed mobility, dressing, bathing, toileting and transfers. The CAA further identified R64 was unable to walk due to amputation and was working with physical therapy (PT) and occupational therapy (OT) for strengthening and to increase independence with activities of daily living (ADL). R64's care plan reviewed on 5/1/19, indicated R64 was at risk for falls due to right BKA, PAD, stroke, coronary artery disease, Diabetes Mellitus and neuropathy. R64's care plan listed various interventions which included the need for extensive assistance with bed mobility, transfers with extensive assist and the EZ- lift (mechanical transfer device) to all destinations, unable to walk due to right BKA (below the knee amputation) and propels wheelchair on and off unit. R64's care plan lacked information regarding a restorative program. On 4/29/19, at 2:22 p.m. R64 was seated in a power wheelchair eating a snack and watched television. R64 indicated she had received PT and OT prior, but was discharged from therapy about a month ago. R64 stated upon discharge from therapy it was her understanding she would receive a restorative nursing program (RNP) for standing, however had not participated in one yet. R64 indicated she had an amputation of the right leg below the knee and wanted to perform the	F 688	sustained: Audits will be conducted. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: MDS nurses/Restorative nursing assistants/DON Date of completion: 6/4/2019	

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RNP so she would have the strength in the left leg to be ready to work with a new prosthetic. R64 indicated she had asked staff a couple times about the RNP and was told the staff would check on it. R64 stated she had not started the program yet and had even stopped in the therapy room earlier that day to check on her RNP.

On 5/1/19, at 11:44 a.m. R64 was seated in the power wheelchair in her room watching television. R64 indicated no further information had been provided regarding the RNP.

On 5/2/19, at 9:16 a.m. R64 was seated on the edge of the bed in a night gown getting set up to eat breakfast in the room. R64 stated she would like to start the RNP for keeping up the strength in the left leg. R64 indicated she had thought about completing the standing by her self, but needed assistance to do so for safety. R64 stated "when my leg is ready for the prosthesis, I want to be ready and do not want to start over." R64 stated when she was discharged from therapy she could stand, holding on to a bar, for 4 to 5 minutes.

On 5/2/19, at 9:25 a.m. nursing assistant (NA)-C stated R64 required extensive assistance with dressing, transfers, toileting and personal hygiene. NA-C indicated residents not receiving therapy services would have a RNP, which was completed by a restorative aide (RA). NA-C stated staff were made aware which resident received an RNP by either information on the Kardex (a condensed version of a care plan), or information would be available to chart on in the section of the electronic health record (EHR) called Point of Care (POC). NA-C reviewed R64's POC charting and indicated R64 was not on a

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RNP.

On 5/2/19, at 9:52 a.m. licensed practical nurse (LPN)-B stated R64 required extensive assistance from staff and the EZ-Stand to transfer and stand. LPN-B indicated R64 was working with therapy to get ready for a prosthetic, but R64 developed a sore on the right leg and had to stop. LPN-B stated R64 was not currently receiving therapy services and was not doing anything with a RNP, and added residents that stay in the facility after therapy discharges usually have a RNP.

On 5/2/19, at 10:02 a.m. registered nurse (RN)-A stated R64 was supposed to receive a prosthetic in the next couple of months and hopefully walk again. She indicated R64 plateaued in therapy and was discharged while they wait for R64 to receive the prosthetic. RN-A reviewed R64's EHR (electronic health record) and stated R64 was working with therapy in March on standing tolerance and was discharged in the beginning of April.

Review of R64's progress notes from 4/1/19 to 5/2/19, revealed the following:

-4/3/19, interdisciplinary team (IDT) met with R64. Discussed therapy discharge and R64 had no further questions.

-4/10/19, staff met with R64 to discuss stay and plans for discharge. R64 no longer working with therapy at this time. Therapy will re-evaluate R64 once prosthetic is being used.

-4/17/19, staff met with R64 and family member. R64 and family member would like more

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information on R64 being on a RNP to continue improving standing tolerance. Staff will pass along this request.

-4/27/19, "[R64] would like to go to therapy and stand at least a couple times a week, will communicate with therapy to see if this is possible."

On 5/2/19, at 10:48 a.m. PT-A stated R64 had been on therapy services a few times with most recent ending in April 2019. PT-A stated R64 was working to prepare the right amputation for prosthetic and worked on standing. PT-A indicated once R64 plateaued in therapy, she was discharged with a RNP to work on standing tolerance. PT-A stated, since R64's program was different than other RNPs, PT-A trained RA to complete the program. PT-A stated she had not seen R64 in the therapy room completing the RNP. PT-A stated once therapy writes RNP recommendations, the RN clinical manager and RA sign the program and it is given to the MDS coordinator (MDSC) to set up the program in the resident's EHR. PT-A stated R64 was in the therapy room last week and had asked about the RNP and PT-A stated she followed up with CM-A and RA-A. PT-A stated further, RNP would be important for R64 for moving forward with a prosthetic and transfer abilities.

Review of Emmanual Nursing Home Restorative Care Transfer Form dated 4/10/19, indicated the reason for transfer was to transfer to RNP to maintain strength gained in skilled therapy and to prevent functional decline. The form further indicated standing tolerance: either at treadmill or parallel bars, place chair without arm rests to her right side to allow her to weight bear through right

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lower extremity. Complete standing two times for 3 to 4 minutes each, three times per week. The form was signed by PT-A on 4/10/19, RA-A on 4/12/19, and RN-A on 4/15/19.

On 5/2/19, at 10:58 a.m. RA-A stated her role was to complete resident's RNP as ordered by therapy. She stated the RA will sign the resident's RNP, make a copy for the RNP room, and then a copy was given to the MDSC to enter into the resident's EHR and the RA staff can chart on each resident's RNP. RA-A indicated she was trained on R64's RNP, but stated RAs had just not gotten to her yet. RA-A stated there were two RAs for the facility, but usually only one worked each day. She indicated when the NAs need help on the floor, the RA staff are asked to assist with cares and are unable to complete their RNP work on those days.

On 5/2/19, at 11:06 a.m. MDSC-A stated part of her role included receiving RNP orders and entering the information into the resident's EHR in POC, Kardex and care plan. MDSC-A stated she had not received R64's RNP until just a few minutes prior, and had just entered R64's RNP into the EHR.

On 5/2/19, at 1:33 p.m. CM-A stated MDSC would be responsible for entering R64's RNP information into the EHR. CM-A indicated MDSC did not know what happened to R64's RNP orders, and stated "something went awry with the process." CM-A stated the facility was currently discussing the process of RNP orders and were updating the order form.

On 5/2/19, at 3:03 p.m. R64 was seated in the power wheelchair in front of the therapy room

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treadmill. R64 with the assistance of PT-A was able to stand, while holding onto the treadmill, per the RNP orders. PT-A stated to R64 her RNP was important to maintain strength and moving forward with R64's goal of a prosthesis.

On 5/3/19, at 9:22 a.m. the director of nursing (DON) stated the usual procedure for residents discharging from therapy would be for therapy to assign an RNP if needed. She indicated therapy staff would then educate the RA on the program and the MDSC enters the program information into the EHR. The DON indicated her expectation would be for the process to be followed. The DON stated the process was changed on 5/2/19, so the MDSC had to sign the form as well to ensure they received a copy of the RNP. The DON stated she was unaware R64's RNP was not being completed.

Review of the facility policy titled Restorative Nursing Program, last revised 11/18, indicated the policy was to promote each resident's ability to adapt to attain his or her maximum functional potential. The policy identified restorative nursing included, but not limited to: skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, range of motion, scheduled toileting and bladder training and bed mobility. The policy further identified implementation of a RNP may also occur following a course of therapy. In these cases, the therapist will provide resident specific training to the appropriate staff, assist the restorative team in establishing initial restorative goals and suggest interventions/approaches. The policy further indicated restorative staff will document the activity and the number of minutes provided each

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F 688	Continued From page 31 time an activity was completed on a designated documentation tool. R86's quarterly Minimum Data Set (MDS) assessment dated 4/16/19, identified R86 had diagnoses which included; dementia, depression, chronic obstructive pulmonary disease (COPD) and subdural hematoma (bruising of the subdural portion of the brain.) The MDS identified R86 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, ambulating and locomotion. The MDS identified R86 used assistive devices for mobility which included a walker and a wheelchair. Further, the MDS identified R86 had received physical therapy (PT) on four days and occupational therapy (OT) on three days out of the seven day assessment period. R86's admission Care Area Assessment (CAA) dated 1/16/19, identified R86 required extensive assistance with ADL's, received PT and OT services to improve her strength and self performance with ADL's. The CAA revealed R86 had moderate cognitive impairment, was able to communicate her needs and participated well in therapies. R86's current care plan revised 4/18/19, revealed R85 required extensive assistance with transfers and ambulation.	F 688		

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R86's nursing assistant Kardex (care guide) revealed R86 was on a nursing restorative program and identified the following exercises; standing exercise with two pound (lb) weight, hip flexion and abduction, extension hamstring curls both twice with 10 repetitions, NuStep (low joint, cardiac impact exercise bike,) level five, 15 minutes, average of 42 steps a minute.

Review of R86's nursing restorative program referral form, dated 4/23/19, identified R86 was referred for the following exercises; standing exercise with two pound (lb) weight, hip flexion and abduction, extension hamstring curls both twice with 10 repetitions, NuStep (low joint, cardiac impact exercise bike,) level five, 15 minutes, average of 42 steps a minute.

On 5/1/19, at 11:18 a.m. R86 was seated in a recliner in her room, eyes were closed, both of her feet were elevated. R86 wore compression stocking (used to treat/prevent swelling(edema),) and had slippers on her feet.

-at 11:28 a.m. R86 remained seated in a recliner in her room, at that time nursing assistant (NA)- E entered her room and proceeded to assist R86 to transfer from the recliner to a wheelchair. NA-E wheeled R86 to the dining room, up to a table and left the dining room.

On 5/2/19, at 9:52 a.m. NA-H stated R86 required standby assistance with transfers and ambulation. NA-H indicated R86 required assistance to walk to and from meals with a walker and gait belt. NA- indicated she was unaware if R86 was on any restorative or maintenance program.

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On 5/2/19, at 10:00 a.m. NA-G stated she was unaware if R86 was on an exercise program and indicated the facility's restorative staff assisted residents with their exercise programs. She indicated, as recently as that day, the restorative aid (RA) was "pulled to the floor" to help with resident cares due to staff call ins. NA-G indicated she was unaware who completed resident exercise programs when the RA was not available.

On 5/2/19, at 1:35 a.m. RA-A stated she had received a referral dated 4/23/19, for R86 on 4/25/19. RA-A stated R86 had been referred for restorative program which included use of the NuStep, standing, hip and leg exercises. RA-A stated R85 had only received one restorative session since she had received R85's referral on 4/25/19. She indicated she was often required to assist resident needs due to lack of staff. RA-A stated she had most recently been pulled away from restorative, that day due to a staff call in. Further, RA-A indicated she attempted to work with resident in the afternoons, however was not always able to.

On 5/2/19, at 1:46 p.m. RN-D stated R86 had recently been discharged from PT services and had been referred to the facility's restorative nursing program. RN-D stated the facility RA would frequently be required to assist with resident care when they were short staffed. She indicated when that occurred the NA's were expected to walk with residents and assist with range of motion exercises, however did not feel that routinely occurred.

On 5/2/19, 2:17 p.m. NA-G stated R86 required extensive assistance with her ADL's, used a

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walker for transfers and a wheelchair for locomotion. NA-G stated R86 was able to walk with the use of a walker and physical assistance. NA-G stated the facility's RA was often required to assist with resident care versus resident restorative programs due to short staffing. NA-G stated was unaware if R86 was on a restorative program.

On 5/2/19, at 3:08 p.m. clinical manager (CM)-B confirmed R86 had been placed on a restorative program to use the NuStep (low impact, arm/leg exercise bike.) on 4/26/19, upon discharge from PT services. NM-B stated the facility's RA was responsible for completing R86's restorative program. NM-B confirmed the facility RA was often required to assist with resident cares when needed, which had been almost daily that week. CM-B stated on the RA's were trained to assist residents with the NuStep and would expect when the RA was not available, the NA's were expected to assist R86 to walk to and from meals.

On 5/2/19, at 3:26 p.m. PT-A stated R86 had been able to ride the NuStep for 15 minutes at an average of 42 steps per minute. At that time, R86 was assisted to the therapy room, onto the NuStep and proceeded to ride the NuStep for a total of 15 minutes at an average of 42 steps per minute. PT-A stated she expected R86's restorative program to be provided to her on a routine basis to prevent R86 from declining in her mobility. Further, PT-A stated she had concerns with the facility's ability to routinely provide residents with restorative services. In addition, PT-A indicated she had been working with facility administration with ways to ensure resident restorative programs were provided timely and routinely.

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On 5/3/19, at 9:21 p.m. the DON stated she would expect R86 to have been provided restorative nursing services as directed by PT. She indicated the facility had two RA's who worked on alternating days, which were trained in providing restorative services. The DON confirmed there were times when the RA was required to assist with resident care versus assisting residents with restorative programs. She indicated when that occurred, she expected the NA's to assist with ambulation, range of motion and were unable to assist with specialized exercises and equipment, such as use of the NuStep. Further, the DON stated the facility was currently working on ensuring restorative services were routinely provided to residents to prevent any decline.

Review of the facility's 11/18 policy Restorative Nursing Program, indicated the policy was to promote each resident's ability to adapt to attain his or her maximum functional potential. The policy identified restorative nursing included, but was not limited to: skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, range of motion, scheduled toileting and bladder training and bed mobility. The policy further identified implementation of a RNP may also occur following a course of therapy. In these cases, the therapist will provide resident specific training to the appropriate staff, assist the restorative team in establishing initial restorative goals and suggest interventions/approaches. In addition, the policy indicated restorative staff were to document the activity, and the number of minutes provided, each time an activity was completed on a

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F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess, monitor and implement pain relief interventions for 1 of 1 resident (R85) reviewed for uncontrolled severe pain. This deficient practice caused actual harm to R85 when she experienced severe pain. Findings include: R85's annual Minimum Data Set (MDS) dated 4/15/19, identified R85 had diagnoses which included dementia, anxiety, depression, osteoarthritis and pain. The MDS identified R85 had severe cognitive impairment, required extensive assistance with activities of daily living (ADL's) which included toileting and bathing. The MDS identified R85 was independent in bed mobility and required supervision for transfers, dressing and grooming. The MDS identified R85 had received scheduled and as needed (prn) analgesics during the seven day look back period, and indicated R85 had denied experiencing pain within the last seven day, when interviewed. R85's annual Care Area Assessment (CAA) dated	F 697	F697 Pain management Corrective action to resident found to be affected: New pain medication initiated and pain controlled. How the facility identified other residents potential to be affected: House audit done to assure no other residents were affected. Measures put in place to ensure it will not recur: Staff education recognition of pain verbal and nonverbal. Nurse Manager to review pain and if pain management is needed, Nurse Manager or supervisor/nurse designee will initiate in the Electronic Medical record increased checks to document pain and ensure pain is being monitored frequently and controlled. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3	6/4/19

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F 697	Continued From page 37 4/15/19, identified R85 had diagnoses which included delusional mood disorder, dementia, anxiety, weakness and had a history of a right hip replacement. The CAA identified R85 required occasional extensive assistance with ADL's, had severe cognitive impairment, had days of confusion and was only oriented to herself and her family and was able to make her needs known. Further, the CAA identified R85 had denied pain when interviewed, however, review of staff notes during the seven-day look back revealed R85 had reported pain to her left hip and had received scheduled and prn analgesics. R85's current pain assessment dated 4/15/19, identified R85 had verbally denied pain within the last seven days when she was asked. R85's pain assessment revealed she was able to "make her needs known." R85's pain assessment revealed staff notes had identified R85 had complained of left hip pain "off and on, had complaints of pain during the seven day look back period and had her pain relieved by scheduled, prn analgesic medications and warm/ice packs as needed. R85's pain assessment identified resident and staff believed R85's pain needs were being met. R85's pain assessment lacked information of her cognition and her ability to routinely, reliably and verbally report pain. Further, R85's pain assessment lacked any indication of R85's non-verbal indicators of pain such as grimacing, moaning, groaning, restlessness, anxiety and/or crying. R85's current care plan reviewed 4/18/19, revealed R85 was at risk for pain, was able to communicate her needs and indicated staff were to observe and ask her about pain. R85's care plan directed facility staff when she had pain, to	F 697	months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: MDS nurses/Restorative nursing assistants/DON Date of completion: 6/4/2019	

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offer non-pharmacological interventions prior to and in conjunction with medications. R85's care plan indicated if her pain was not relieved staff were to notify her medical doctor (MD) and family and await response. Further, R85's care plan revealed she was at risk for ineffective coping and alterations in mood and behavior due to pain, dementia, anxiety and depression.

Review of an undated facility nursing assistant (NA) care guide revealed R85 required assistance of one to two staff with walking and care. The care guide revealed staff were to check on R85 every two hours.

Review of R85's physician orders from 4/26-5/1/19, revealed the following orders for pain management;

-4/26/19: R85 was not walking well, had facial grimacing, family requesting comfort cares. An order for Tramadol 50 mgs (milligrams) by mouth three times a day (TID) for moderate pain thru 4/29/19, was obtained.

-4/28/19: R85 continued to have severe pain, an order was received to discontinue Tramadol and to initiate morphine 10 mg/5 ml (milliliters), 2.5 mg every two hours as needed (PRN) for pain was received.

-4/30/19, R85 continued to have severe pain, order received to schedule R85 morphine 2.5 mg every six hours while awake and to continue morphine 2.5 mg every two hours prn.

-5/1/19, R85 continued to have severe, uncontrolled pain, order received to increase R85's morphine to 5 mg every six hours while

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awake and to continue morphine 2.5 mg every two hours prn.

Review of R85's Medication Administration Record (MAR) on 4/30/19, revealed the following;

- an order dated 4/28/19, indicated the use of morphine sulfate 10 mg/5 ml, 2.5 mg every two hours PRN for pain management. The MAR revealed R85 had received two out of three prn doses.

-an order dated 4/30/19, for morphine sulfate 10 mg/5 ml, 2.5 mg every six hours when awake for pain management. The MAR revealed R85 had received scheduled morphine at 3:00 p.m. R85's MAR revealed a scheduled 9:00 p.m. dose of morphine was not given.

Review of R85's MAR for 5/1/19, revealed the following:

-The MAR revealed R85 had received two doses of morphine 2.5 mg, one at 3:00 a.m. and one at 9:00 a.m.

The MAR revealed R85 had not received any PRN doses.

On 4/30/19 at 9:46 a.m., R85 was observed seated in a reclined position on a recliner in her room, her eyes were open, jaw was clenched tightly, brow was furrowed as she repeatedly moved her legs up and down in a withering movement. R85's family member (FM)-B was seated to the left of her on the bed in her room. FM-B held R85's hand and indicated R85 was not feeling well and was having a lot of pain. FM-B stated R85 had recently had a significant change

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in condition, as she was more confused, needed more assistance with ADL's and was experiencing a lot of pain. FM-B stated a sibling had met with R85's clinical nurse manager (CM)-B regarding R85's increased pain and overall discomfort, and indicated R85 had some recent medication changes as a result. FM-B stated hospice had evaluated R85 for end of life services however, had determined she did not meet the criteria. FM-B stated upon discussion with CM-B, they had decided R85 would be placed on comfort cares by the facility. FM-B stated he was under the impression comfort cares included pain management and overall comfort of R85. FM-B stated he did not feel R85's pain was currently managed because she had difficulty sitting still, would wither in pain at times, cried, and at times looked scared. Upon leaving R85's room at 9:58 a.m. R85 continued to grimace, held her jaw tightly and repeatedly moved her legs up and down while in a reclined position.

On 5/1/19, during continuous observations of R85 from 7:00 a.m. to 9:20 a.m. the following was revealed;

-At 7:00 a.m. R85 was lying in bed on her back, eyes were closed, she had a large blue pillow on her right and her left side and was covered with a blanket from her feet to her mid chest.

-at 7:47 a.m. R85 remained lying in bed on her back, here eyes were closed and she began to moan. R85's was laying in bed, repeatedly moaned and made repeated guttural sounds, which were heard from the hallway. R85's brow was furrowed, her jaw was tight and she had tears running down the corners of her eyes. At

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that time, registered nurse (RN)-C was observed two doors down from R85's room. No staff were observed to enter R85's room.

-at 7:50 a.m. R85 remained laying in bed on her back, had a deep, guttural moan, was breathing heavily and continued to have tears running from the corner of her eyes. R85's moaning could be heard from the hallway.

-at 7:51 a.m. R85 was laying in bed, raised her left arm, reached for a metal assist bar on the left side of her bed and pulled herself into a sitting position with her legs over the blue pillow and placed her feet onto the floor. R85 gutturally groaned when she sat up, her brow was furrowed, her jaw was clenched tightly and she continued to have tears running down from her eyes. R85 reached for a pair of slippers with her feet, donned them and began to whimper. R85 continued to moan deeply and could be heard from the hallway. No staff were observed to offer R85 assistance.

-At 7:54 a.m. R85 remained seated on the edge of her bed, her brow was furrowed, jaw clenched, tears ran down her cheeks while she continued to moan and groan. Nursing assistant (NA)-E entered R85's room, approached R85, donned a gait belt across R85's waist and assisted R85 to a standing position. R85 was moaning, breathing heavily and her whole body began to shake upon standing. NA-E assisted R85 to sit in a wheelchair, wheeled her to the bathroom and assisted R85 to the toilet and proceeded to assist her with morning cares. R85's jaw was clenched, brow was furrowed, her whole body shook, and she whimpered throughout the morning cares.

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-At 8:13 a.m. R85 remained seated on the toilet, her jaw was tight, brow was furrowed while she her entire upper body shook. R85's voice was shaky as she attempted to talk to NA- E. At that time, NA-F entered R85's room, proceeded to assist R85 to transfer from the toilet to a wheelchair. R85 grimaced and her breathing became labored during the transfer. R85 was then wheeled to the dining room to a table. NA-D sat next to R85 to assist her with eating. NA-D attempted to engage R85 in conversation, however R85's upper body continued to shake, her voice shook when she attempted to answer NA-D, R85's brow was furrowed, jaw was tight and her breathing was labored throughout the meal.

-at 8:23 a.m. R85 remained seated in a wheelchair at the dining room table, her jaw remained tight, brow was furrowed, she frowned and whimpered between small bites of oatmeal that NA fed her. At that time, FM-E entered the dining room, sat next to R85 and proceeded to encourage R85 to eat and drink. R85 was observed to eat approximately 25% of her entire meal.

-at 8:40 a.m. R85 was seated in a wheelchair while NA-F wheeled her to her room. R85's upper body continued to shake, she had tears running down her cheeks. NA-F assisted R85 to the bathroom with a walker and a gait belt. R85 deeply groaned and shook throughout the transfer.

-at 8:52 a.m. R85 was wheeled from the bathroom, to a recliner in her room NA-F assisted R85 to transfer to the recliner with the assistance of FM-E. R85's body shook, her jaw was tight,

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tears ran from her eyes throughout the transfer. R85 was covered with a blanket and assisted into a reclined position. FM-E was in the room and remained with R85, holding her hand.

Throughout the aforementioned observations, no staff were observed to ask R85 if she was in pain, or were observed to notify R85's nurse of her non-verbal signs of severe pain.

-At 9:20 a.m. R85 was seated in her recliner as FM-B entered R85's room. R85 stated in a shaky, trembling voice she needed to go to the bathroom. FM-B moved R85 from a reclined to a seated position, turned on R85's call light. R85 had tears running down her cheeks, moaned and her entire upper body shook. At that time, RN-C, entered R85's room, administered liquid morphine for pain, and proceeded to assist R85 to stand from the recliner. R85 was assisted to the bathroom and back to the recliner in her room. R85 shook, moaned and continued to have tears falling down her cheeks throughout the observation.

-At 9:41 a.m. R85 was observed seated in a recliner in her room, both FM-E and FM-B were present. At that time, FM-B indicated R85 appeared uncomfortable and unsettled. R85's eyes were closed, brow was furrowed, jaw was tight and her mouth was frowned. R85 began to mumble, unintelligible words, took a deep, shaky breath and frowned.

-At 11:07 a.m. R85 was observed seated upright in a recliner in her room, covered with a blanket from her feet to her torso, eyes were open widely, her jaw was clenched. R85 repeatedly looked side to side with wide eyes and she moaned and

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groaned between labored breaths. R85 pulled the blanket off of her legs, leaned forward, deeply groaned, leaned back and covered herself back up. R85's upper body began to shake, she called out unintelligible words. R85's entire upper body shook as she groaned and began to rock back and forth in the recliner.

-At 11:12 a.m. R85 removed the blanket from her legs and attempted to stand from her recliner as her entire body began to shake. R85 stood partially erect, her body continued to shake violently, she whimpered and moaned. At that time, RN was in the hallway outside of R85's room, approximately 20 feet away from her door. RN-C was notified of R85's position and she immediately entered R85's room and walked over to R85 and assisted her back to a seated position in the recliner. R85 continued to shake, tears streamed down her cheeks, and stated to RN-C in a shaky voice, " I cannot do this." RN-C sat on the bed next to R85's recliner and asked R85 if she was in pain. R85's upper body continued to shake uncontrollably, and R85 was unable to articulate if and or where she was having pain, RN-C indicated she had just given R85 a dose of morphine for symptoms of severe pain. At that time, FM-B entered her room, sat across from R85 and held onto her hand. RN-C indicated she would contact R85's physician and request her scheduled morphine be increased. RN-C left R85's room, obtained a warmed blanket, notified FM-B of R85's pain and both walked back to R85's room. R85 remained seated in a recliner, her upper body shook, her jaw was clenched, her eyes were wide and her breathing was labored. R85 was assisted to bed by RN-C and CM-B. At that time, CM-B met with R85's family members.

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On 5/1/19, at 8:11 a.m. NA-E stated she felt R85 was rapidly declining and indicated R85 used to be independent approximately three weeks ago. NA-E stated R85 was often confused and "jittery" when she was assisted with any ADL and indicated she felt R85 was not fully aware of what was going on around her. NA-E stated R85 used to be able to inform staff of her needs and if she was uncomfortable or in pain. NA-E stated she did not feel R85 was able, at that time, to verbalize to staff if she was having any pain. Further, NA-E stated if she thought R85 was in pain or uncomfortable she would notify the nurse.

On 5/1/19, at 8:46 a.m. FM-E stated R85's overall condition had been declining, rapidly in the past few weeks. FM-E stated he felt R85 was no longer to verbalize her needs like she used to and felt she was no longer able to verbalize when she was in pain. FM-E stated within the last week R85 had appeared to be in significant pain as she would moan, grimace and cry. FM-E stated at least one family member was at the facility with R85 on a daily basis for the last week due to concern for her discomfort. FM-E stated the facility staff had been giving R85 medication, though did not feel the current regimen was effective in managing R85's pain.

On 5/1/19, at 9:40 a.m. RN-C stated she did not feel R85 was able to articulate specifically that she was in pain, though felt R85 showed signs of pain such as repeated sighing, grimacing, jaw tightening and anxiety. RN-C stated she had given R85 scheduled morphine around approximately 9:00 a.m. and stated as of that time, R85 had not received any additional doses of morphine before or after the scheduled dose. RN-C stated she had not been notified of any

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concerns regarding R85 from any of the NA's. RN-C stated she did not feel R85's pain was managed at that time.

During a telephone interview on 5/1/19, at 12:12 p.m. R85's FM-A stated within the last couple of weeks R85 had significantly declined in her overall condition. FM-A stated in the past two weeks, R85's pain has significantly worsened as had her anxiety. FM-A stated she and her other family members had met with facility as recently as the day prior regarding R85's pain management. FM-A stated she and other family members had spoken with NM-B on 4/30/19, and they had decided R85 was to be given morphine (every two hours) from the evening of 4/30/19, to today in order to get her pain under control. FM-A stated she had concerns with facilty staff not providing R85 with timely pain relief. FM-A further stated she felt R85 had declined so rapidly and continued to change, that some staff were not aware R85 was no longer able to verbalize what she needed.

During a telephone interview on 5/1/19, at 12:32 p.m. R85's FM-C stated she had significant concerns R85 was and continued to be in severe pain and felt the facility's nursing staff were not "getting on top of R85's pain." FM-C stated on the evening of 4/30/19, she had been with R85 for most of the evening and into the night. FM-C stated she felt R85 was very uncomfortable, kept tossing and turning and would indicated she hurt. She stated R85 had difficulty in telling her where she hurt, though she had been able to discern her head, hip and back were hurting R85. FM-C stated she had met with NM-B on 4/29/19, regarding R85's appearing severe discomfort and indicated at that time, R85's pain medication had

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been changed from tramadol to morphine. FM-C stated on 4/30/19, she had met with NM-B again due to R85 continued severe pain, and had been told R85 would receive routine pain medication (morphine) every two hours throughout the night in order to better manage R85's pain. FM-C stated she did not feel R85 had received any pain medication throughout the night from 4/30/19, to 5/1/19.

On 5/2/19, at 9:37 a.m. R85's FM-D and FM-B stated they had arrived at the facility at approximately 7:00 a.m. that morning. FM-B stated R85 had a rough night and had not had a good morning. FM-D stated he did not feel R85's pain was managed and they did not feel the facility staff had provided pain relief in a timely manner. FM-D stated they had ongoing concerns with facility staff intervening in a timely manner with R85's pain.

On 5/2/19, at 9:40 a.m. NA-F stated she had not provided care to R85 for the past few weeks up until the day prior and felt R85 had significantly declined in her ADL's and was no longer able to verbalize her needs. NA-F stated R85 required extensive assistance of two staff with ADL's and indicated she felt R85 was in pain and fearful. She stated R85 had been moaning, groaning and tearful frequently in the last two days.

On 5/2/19, at 9:46 a.m. NA-H stated R85 currently required increased assistance with ADL's and was no longer able to verbalize her needs and wishes. She stated R85 appeared uncomfortable and would frequently become tearful, would moan and groan and appeared to be in pain.

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 5/2/19, at 9:54 a.m. NA-G stated R85 was no longer able to let staff know of her needs and her needs had to be anticipated by facility staff. NA-G stated within the last couple of weeks, R85 was restless, tearful, would moan and groan and she felt R85 was in pain.

On 5/2/19, at 10:05 a.m. a telephone call was placed to R85's primary physician (MD)-A, a message was left with her nurse.

On 5/2/19, at 10:37 a.m. R85's medical record was reviewed with CM-B. Upon review of R85's April and May, 2019, Medication Administration Record, CM-B confirmed R85 had not received morphine every two hours throughout the night of 4/30/19, to 5/1/19, per her discussion with R85's family members. CM-B confirmed R85 had not received two doses of morphine at 5:00 a.m. and 7:00 a.m. CM-B stated she was made aware of R85's severe uncontrolled pain on the morning of 5/1/19, and stated she had expected R85 to have received doses of morphine every two hours throughout the night. CM-B stated she felt R85's pain had not been managed at the time and indicated she continued to work with R85's physician and her family members to keep R85 comfortable. Review of R85's progress notes with CM-B revealed from 4/15/19, to the current date R85 had increased pain, anxiety and had increased confusion. She confirmed on 4/26/19, eleven days following R85's signs and symptoms of increased pain, R85's primary physician had ordered Tramadol three times a day for pain. CM-B confirmed R85 had routinely received Tramadol from 4/26/18, to 4/29/19, and verified R85 had continued to experience severe uncontrolled pain. CM-B stated on 4/28/19, an order for as needed morphine had been received

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and the Tramadol had been discontinued. She confirmed R85 continued to experience severe uncontrolled pain. CM-B confirmed R85 had not been offered morphine until R85 had symptoms of severe pain. She indicated she expected nursing staff to observe for early signs of pain and to intervene before R85's pain level reached a severe level. CM-B stated on 4/29/19, R85's order for morphine was changed to scheduled every six hour administration and as needed every two hours. CM-B stated R85's pain was still not managed and the morphine was increased from 2.5 mg to 5 mg on 5/1/19. She stated she had again discussed R85's medication schedule with her staff to ensure R85's pain was better managed. Further, CM-B stated she would expect staff to observe R85 for signs of pain, which included; grimacing, moaning, labored breathing, restlessness and crying.

On 5/2/19, at 1:50 p.m. RN-D stated R85 had significantly declined in the past few weeks with her ADL's, cognition and had increase pain and anxiety. She indicated R85 was no longer able to verbalize when she was in pain, and stated she had to observe R85 for signs of pain. RN-D indicated R85 frequently exhibited the following non-verbal indicators of pain; grimacing, moaning, labored breathing, restlessness and crying. Further, RN-C stated she had administred morphine to R85 every two hours since she arrived that morning as she felt R85 had been very uncomfortable.

On 5/2/19, at 2:27 p.m. the DON confirmed R85 had significantly declined within the last few weeks and was no longer able to routinely and reliably verbalize her needs. The DON stated she expected R85's pain management plan to be

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followed and would expect staff to observe R85 for non-verbal indicator of pain; grimacing, moaning, labored breathing, restlessness and crying.

On 5/2/19, at 3:57 p.m. during a telephone interview with R85's primary physician (MD)-A, she stated she had been made aware R85 had constant, severe, uncontrolled pain. MD-A stated she would expect the facility nursing staff to provide routine and consistent pain relief to R85. She stated she expected R85's physician orders and NM directions to be followed and felt if R85 had not been provided with routine pain intervention, she certainly would have worsening, uncontrolled pain. MD-A stated she was not clear on where R85's pain was located or the cause of her pain. However, she stated after conversation with R85's family members, they had decided against any diagnostic testing and requested R85 be kept as comfortable as possible. MD-A stated she felt R85's pain could be managed with routine pharmacological and non-pharmacological interventions. Further, MD-A confirmed she had not seen R85 in the facility since she had an abrupt increase in pain.

On 5/3/19, at 9:59 a.m. during a follow up interview with the DON, she stated R85 had been more comfortable that morning and felt the facility staff had tried to manage R85's pain. She stated she had spoken with R85's nurse who had worked with her on the night of 4/30/19, to 5/1/19, and she confirmed R85 had not received a 5:00 a.m. and 7:00 a.m. doses of morphine as R85 had been sleeping. However, the DON confirmed R85 had non-verbal indicators of pain on the morning of 5/1/19, as was evident by shaking uncontrollably, moaning, groaning, labored

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F 697	Continued From page 51 breathing and crying. Review of a facility policy titled, Pain Management, revised 8/2016, identified it was the purpose of the policy was to provide effective pain management that resulted in an optimal level of comfort while maintaining as much function as possible and to assist residents to achieve their highest level of pain management.	F 697		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		6/4/19

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F 756	Continued From page 52 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist (CP)identified and reported an irregularity related to the lack of timely tardive dyskinesia (TD) screenings (an assessment of involuntary movements) for 1 of 5 residents (R244) reviewed for unnecessary medications. Findings include: R244's admission Minimum Data Set (MDS) assessment dated 4/23/19, indicated R244 was admitted on 4/17/19, and had diagnoses of Alzheimer's disease, dementia, delirium due to known physiological condition, fracture, and history of falls. The MDS identified R244's cognitive skills for daily decision making were severely impaired and R244 required extensive assistance for bed mobility, transfers, dressing and toileting, and limited assistance for walking and personal hygiene. The MDS further indicated R244 had continuously present inattention, no hallucinations or delusions, physical behaviors towards others on 1 to 3 days of the assessment and no rejection of care. The MDS identified R244 wandered 1 to 3 days of the assessment,	F 756	F756 Drug Regimen Review Corrective action to resident found to be affected: Tardive dyskinesia (TD) screening assessment (AIMS) was completed for R244. How the facility identified other residents potential to be affected: All drug regimen reviews audited for any irregularities and recommendations taken per pharmacy review. In addition, charts were audited to ensure all TD assessments were completed. Measures put in place to ensure it will not recur: Facility policy for TD screening reviewed with consultant pharmacist and staff. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will	

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F 756	Continued From page 53 had two or more falls since admission, received an antipsychotic each day of the assessment and an antidepressant and antianxiety medication six days of the assessment. R244's Care Area Assessments (CAA) dated 4/23/19, indicated R244 was at risk for falls and alterations in behavior due to medication use, poor balance, history of falls, diagnoses and weakness. The CAA further indicated R244 had several episodes of agitation and aggressive behaviors since admission. The CAA identified "Staff attempt to redirect and orient during these times. [R244] is also given PRN Haldol [antipsychotic medication] and Ativan [antianxiety medication]." R244's care plan, last revised 5/2/19, indicated R244 used psychotropic medications related to behavior management. R244's care plan listed various interventions which included administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift and monitor/document/report PRN any adverse reactions of psychotropic medications which included: unsteady gait, tardive dyskinesia, extrapyramidal symptoms (shuffling gait, rigid muscles, shaking), frequent falls and behavior symptoms not usual to the person. Review of R244's physician orders from 4/17/19 to 5/3/19, revealed: -4/17/19, R244's orders included: Seroquel (antipsychotic medication) 12.5 milligram (mg) by mouth (PO) two times a day. Seroquel 12.5 mg PO two times a day PRN for delirium, hallucination.	F 756	be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors, DON, Pharmacy Consultant, MDS Coordinators Date of completion: 6/04/19	

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Haldol (antipsychotic medication) 2.5 mg injection every 6 hours PRN may use oral tabs if patient able to swallow Haldol 2.5 mg PO.

-4/18/19, R244's orders included:
Discontinue PRN Seroquel and Haldol
Increase Seroquel to 25 mg at 8:00 a.m. and Seroquel 37.5 mg at 6:00 p.m.
One time dose of Seroquel 12.5 mg STAT (as soon as possible).
Ativan 0.5 mg PO every 4 hours PRN for anxiety, agitation, restlessness if unable to administer PO may use 1 mg Ativan intramuscular (IM) injection once and update provider.

-4/25/19, R244's order included:
Increase Seroquel to 50 mg at every bedtime.
Discontinue IM Ativan, continue PO PRN Ativan.

-4/30/19, R244's order included:
Increase evening dose of Seroquel to 75 mg PO daily; may give later than 6:00 p.m. if needed.

-5/2/19, R244's order included:
Add Seroquel 12.5 mg at noon.

Review of R244's electronic health record (EHR) revealed no TD assessment.

On 5/3/19, at 10:12 a.m. registered nurse (RN) clinical manager (CM)-A stated antipsychotic medication adverse reactions were monitored on the resident's treatment administration record (TAR). CM-A indicated the facility also used the Abnormal Involuntary Movement Scale (AIMS) to assess residents for TD. CM-A stated a baseline AIMS was completed upon admission for all residents with orders for an antipsychotic and the MDS coordinator (MDSC) completed the AIMS

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F 756	Continued From page 55	F 756		

assessment. CM-A reviewed R244's EHR and confirmed no TD assessment had been completed.

On 5/3/19, at 10:17 a.m. MDSC-B stated completing AIMS assessments for TD monitoring was part of the MDSC's role. MDSC-B indicated a baseline AIMS assessment was completed within the first week of a resident's admission and quarterly after that to monitor for TD. MDSC-B reviewed R244's EHR and confirmed a TD assessment had not been completed. MDSC-B stated "I can't believe I missed that [AIMS assessment]." MDSC-B stated R244 had recently started on antipsychotics and has had a rapid decline. MDSC-B indicated a baseline TD assessment would be important for R244 due to being newer to antipsychotic medications and risk for TD.

On 5/3/19, at 1:15 p.m. during a phone interview consultant pharmacist (CP)-A indicated part of her role was to review residents' physician orders and identify potential irregularities and report the irregularities to the residents' physician and facility staff, which included the DON and the medical director. CP-A indicated facility staff should be monitoring TD with an AIMS assessments. CP-A stated a baseline AIMS assessment should be completed as soon as possible when a resident was admitted. CP-A stated since R244 was admitted in the last 30 days, she would not have looked to see if a baseline TD assessment was complete until the next monthly visit, so facility staff could have time to follow their process for TD assessments.

On 5/3/19, at 1:35 p.m. the director of nursing (DON) indicated the facility utilized the AIMS

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F 756	Continued From page 56 assessment for monitoring TD for residents with an ordered antipsychotic. The DON stated the baseline AIMS was expected to be completed within the first 14 days upon admission and then every six months. The DON indicated the baseline AIMS was important so staff would know the resident's baseline and track changes with TD side effects from antipsychotic medication use. The DON stated she would have expected the CP to review if R244 had a baseline TD assessment during the medication regimen review competed 4/29/19. The DON indicated R244 would be at risk for TD due to antipsychotic use. Review of the facility policy titled Pharmacist's Drug Regimen Review, last revised 11/13, indicated the licensed pharmacist will review the drug regimen of each resident at least once a month. The pharmacist will report any irregularities to the DON, or associate DON and the attending physician, and these reports would be acted on by the time of the next physician visit or sooner if warranted by the pharmacist. Review of the facility policy titled Tardive Dyskinesia, last revised 2/16, indicated residents prescribed antipsychotics are regularly an systematically assessed and evaluated for TD. The policy further indicated residents who receive medications where TD was a possible side effect are assessed prior to starting such medications; or within 14 days of admission.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		6/4/19

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F 758	Continued From page 57 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 58 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete timely tardive dyskinesia (TD) screenings (assessment for involuntary movements) for 1 of 5 residents (R244) who received a routine dose of an antipsychotic medication. In addition, the facility failed to ensure pharmacist recommendations were acted upon with the appropriate rationale recorded for not implementing recommendations for 1 of 5 residents (R244) reviewed for unnecessary medication use. Findings include: R244's admission Minimum Data Set (MDS) dated 4/23/19, indicated R244 was admitted on 4/17/19, and had diagnoses of Alzheimer's disease, dementia, delirium due to known physiological condition, fracture, and history of falls. The MDS identified R244's cognitive skills for daily decision making were severely impaired and R244 required extensive assistance for bed mobility, transfers, dressing and toileting, and limited assistance for walking and personal hygiene. The MDS further indicated R244 had continuously present inattention, no hallucinations or delusions, physical behaviors towards others on 1 to 3 days of the assessment and no rejection of care. The MDS identified R244 wandered 1 to 3 days of the assessment, had two or more falls since admission, received an antipsychotic each	F 758	F 758 Free from Unnec Psychotropic Meds/PRN Use Corrective action to resident found to be affected: Medication was discontinued. How the facility identified other residents potential to be affected: All medication records audited and reviewed. Measures put in place to ensure it will not recur: Education provided to staff regarding PRN psychotropic drugs and the necessary documentation and follow up required. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: RN Managers/Supervisors, DON Date of completion: 6/04/19	

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day of the assessment and an antidepressant and antianxiety medication six days of the assessment.

R244's Care Area Assessments (CAA) dated 4/23/19, indicated R244 was at risk for falls and alterations in behavior due to medication use, poor balance, history of falls, diagnoses and weakness. The CAA further indicated R244 had several episodes of agitation and aggressive behaviors since admission. The CAA identified "Staff attempt to redirect and orient during these times. [R244] is also given PRN Haldol [antipsychotic medication] and Ativan [antianxiety medication]."

R244's care plan, last revised 5/2/19, indicated R244 used psychotropic medications related to behavior management. R244's care plan listed various interventions which included administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift and monitor/document/report PRN any adverse reactions of psychotropic medications which included: unsteady gait, tardive dyskinesia, extrapyramidal symptoms (shuffling gait, rigid muscles, shaking), frequent falls and behavior symptoms not usual to the person.

Review of R244's physician orders from 4/17/19 to 5/3/19, revealed:

-4/17/19, R244's orders included:
Seroquel (antipsychotic medication) 12.5 milligram (mg) by mouth (PO) two times a day.
Seroquel 12.5 mg PO two times a day PRN for delirium, hallucination.
Haldol 2.5 mg injection every 6 hours PRN may

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EMMANUEL NURSING HOME	**1415 MADISON AVENUE DETROIT LAKES, MN 56501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 60	F 758		

use oral tabs if patient able to swallow Haldol 2.5 mg PO.

-4/18/19, R244's orders included:
Discontinue PRN Seroquel and Haldol
Increase Seroquel to 25 mg at 8:00 a.m. and Seroquel 37.5 mg at 6:00 p.m.
One time dose of Seroquel 12.5 mg STAT (as soon as possible).
Ativan 0.5 mg PO every 4 hours PRN for anxiety, agitation, restlessness if unable to administer PO may use 1 mg Ativan intramuscular (IM) injection once and update provider.

-4/25/19, R244's order included:
Increase Seroquel to 50 mg at every bedtime.
Discontinue IM Ativan, continue PO PRN Ativan.

-4/30/19, R244's order included:
Increase evening dose of Seroquel to 75 mg PO daily; may give later than 6:00 p.m. if needed.

-5/2/19, R244's order included:
Add Seroquel 12.5 mg at noon.

Review of R244's electronic health record (EHR) revealed no TD assessment.

On 5/3/19, at 10:12 a.m. registered nurse (RN) clinical manager (CM)-A stated antipsychotic medication adverse reactions were monitored on the resident's treatment administration record (TAR). CM-A indicated the facility also used the Abnormal Involuntary Movement Scale (AIMS) to assess residents for TD. CM-A stated a baseline AIMS was completed upon admission for all residents with orders for an antipsychotic and the MDS coordinator (MDSC) completed the AIMS assessment. CM-A reviewed R244's EHR and

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confirmed no TD assessment had been completed.

Review of R244's TAR from April 2019 to May 2019, revealed:

-April 2019, Antipsychotic medication-Monitor for arrhythmia (irregular heartbeat), dizziness, hyperglycemia (high blood sugar), orthostatic hypotension (a drop in blood pressure when standing up or bending over), restlessness, sedation, weakness, weight gain, extrapyramidal side effects, pseudo-Parkinsonism (movement disorder), akathisia (movement disorder), dystonia (sustained muscle contractions leading to abnormal postures), TD and anticholinergic side effects. The monitoring was ordered to start on 4/17/19, and was discontinued on 4/25/19. No further antipsychotic medication side effect monitoring was noted.

-May 2019, no antipsychotic medication side effect monitoring was noted.

On 5/3/19, at 10:17 a.m. MDSC-B stated completing AIMS assessments for TD monitoring was part of the MDSC's role. MDSC-B indicated a baseline AIMS assessment was completed within the first week of a resident's admission and quarterly after that to monitor for TD. MDSC-B reviewed R244's EHR and confirmed a TD assessment had not been completed. MDSC-B stated "I can't believe I missed that [AIMS assessment]." MDSC-B stated R244 had recently started on antipsychotics and has had a rapid decline. MDSC-B indicated a baseline TD assessment would be important for R244 due to being newer to antipsychotic medications and risk for TD.

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On 5/3/19, at 1:15 p.m. during a phone interview consultant pharmacist (CP)-A indicated facility staff should be monitoring TD with an AIMS assessment. CP-A stated a baseline AIMS assessment should be completed as soon as possible when a resident was admitted, or when newly started on an antipsychotic and at least every six months after that.

On 5/3/19, at 1:35 p.m. the director of nursing (DON) indicated the facility utilized the AIMS assessment for monitoring TD for residents with an ordered antipsychotic. The DON stated the baseline AIMS was expected to be completed within the first 14 days upon admission and then every six months. The DON indicated the baseline AIMS was important so staff would know the resident's baseline and track changes with TD side effects from antipsychotic medication use. The DON indicated R244 would be at risk for TD due to antipsychotic use.

ATIVAN RATIONALE:

R244

Review of Consultant Pharmacist's Medication Review dated 4/29/19, indicated R244's physician ordered Ativan 0.5 mg every four hours as needed (PRN) triggered for an irregularity due to "PRN psychotropics such as this are limited to a 14-day duration based on updated CMS [Centers for Medicare and Medicaid Services] guidance and rules, unless the prescriber chooses to extend treatment by providing clinical rationale and documenting intended duration". The form further indicated "Recommend re-evaluating appropriateness of continuing current therapy. If

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continued, please add an appropriate stop date for the above psychotropic medication. If treatment is to be continued, please document duration of treatment and document clinical evaluation/rationale of the resident." The form identified the physician was to address the concern "ASAP [as soon as possible] but no later than 7 days." R244's physician reviewed the form on 5/2/19, and chose to reject the recommendation and added, "Patient currently on hospice with behaviors." However, the form lacked an appropriate stop date for the PRN Ativan, and lacked duration of treatment and clinical evaluation/rationale of R244.

Review of R244's signed physician provider note dated 5/2/19, indicated R244 was evaluated by the physician. The note identified R244 had been receiving Ativan PRN for periods of restlessness, agitation and irritability. The note further identified R244's Ativan to be used PRN, however, the provider note lacked an appropriate stop date for the PRN Ativan, and lacked duration of treatment and clinical rational for continued PRN Ativan.

On 5/3/19, at 1:15 p.m. during a phone interview with CP-A, she indicated part of her role was to review residents' physician orders and identify potential irregularities and report to the residents' physician and facility staff, which included the DON and the medical director. CP-A stated when a PRN psychotropic medication was ordered, than the order must include a duration and a rationale. CP-A indicated the expectation for R244's irregularity would have been for the provider to address the CP's comments/concerns or discontinue the medication.

On 5/3/19, at 1:35 p.m. the DON stated CP-A

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F 758	Continued From page 64 comes to the facility monthly to complete a medication regimen review of each resident. The DON indicated the process for identified irregularities was, CP-A identified them, documented on the Consultant Pharmacist's Medication Review form and nursing staff gave the information to the residents' physician to either accept or reject the recommendation and provide the required documentation. Review of the facility policy titled Tardive Dyskinesia, last revised 2/16, indicated residents prescribed antipsychotics are regularly an systematically assessed and evaluated for TD. The policy further indicated residents who receive medications where TD was a possible side effect are assessed prior to starting such medications; or within 14 days of admission. Review of the facility policy titled Pharmacist's Drug Regimen Review, last revised 11/13, indicated the licensed pharmacist will review the drug regimen of each resident at least once a month. The pharmacist will report any irregularities to the DON, or associate DON and the attending physician, and these reports would be acted on by the time of the next physician visit or sooner if warranted by the pharmacist. The policy further indicated the attending physician will sign or initial the form, indicating their review of the comment made by the pharmacist and will document any further responses.	F 758		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 814		6/4/19

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F 814	Continued From page 65 by: Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpsters to prevent pests and rodent issues. This had the potential to affect all 93 residents residing in the facility. Findings include: On 4/29/19 at 1:14 p.m., a tour of the facility's kitchen area was conducted with dietary manager (DM)-A. During the observation, three facility dumpsters located in the back of the building were observed from a kitchen window. All three dumpsters were uncovered and had large black garbage bags piled on top of each other extending above the top of the dumpsters. On 5/3/19 at 9:25 a.m., two dumpsters were observed to be overfilled. The dumpsters were observed to be uncovered, with black garbage bags piled on top of each other. On 5/3/19 at 9:32 a.m., the environmental services director (ED) verified the three refuse dumpsters were either uncovered or over filled. The ED reviewed the garbage pick up schedule with the environmental technician (ET)-A via telephone. The ED verified the refuse dumpsters were picked up three times a week, Monday, Wednesday, and Friday. ED- A stated it was a constant battle to ensure staff were placing the garbage bags into the dumpsters and closing the lids. ED-A indicated he believed the garbage pick up schedule was adequate, however stated staff were to place the garbage bags in the dumpsters and close the lids as it was unknown if the dumpsters were full or merely filled on the one side.	F 814	F814 Dispose Garbage and Refuse Properly Corrective action to resident found to be affected: Garbage was removed per waste management and all trash was contained in the dumpster with lids closed. How the facility identified other residents potential to be affected: All dumpsters were checked and lids closed with garbage and refuse properly contained. Measures put in place to ensure it will not recur: Staff educated and policy reviewed and updated. Waste management contract reviewed and waste pick up frequency is adequate. How the facility will monitor its performance to ensure solutions are sustained: Audits will be conducted weekly x 4 weeks then Monthly x3 months. After completion of audits it will be reviewed at the QAPI meeting and determined if additional audits are necessary based on findings. Responsible Persons: Environmental services Date of completion: 6/04/19	

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F 814	Continued From page 66 On 5/3/19, at 1:00 p.m. the administrator verified garbage should be placed into the dumpsters, however could not say wether or not it was routine for the dumpsters to be uncovered and overfilled. The administrator stated it was something that should be looked into. The facility's policy for garbage pick up was requested, but was not provided.	F 814		

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

F5489028

PRINTED: 06/03/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 - 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 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code NFPA 99 "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/30/2019

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.

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K 000	Continued From page 1 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 addition to the east wing was constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was	K 000		

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K 000	Continued From page 2 determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111) construction. In 2004 a separate building (building 02) was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated form the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. In 2014 the Transitional Care was added and was determined to be of Type II (111) construction. The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code". The 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations. The facility has a capacity of 102 beds and had a census of 95 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222	Egress Doors	K 222		4/30/19

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K 222 SS=F	Continued From page 3 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		

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K 222	Continued From page 4 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the proper operation of exit door locking devices. NFPA 101, Life Safety Code, 2012 edition section 19.2.2.2.2. This deficient practice could cause the door not to open and affect an undetermined amount of residents and staff. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/30/2019 observations revealed the gate exiting the courtyard was locked with a padlock and plastic chain. All staff did not have a key for this lock.	K 222	1) The plastic chain and padlock have been removed from the Memory Care courtyard gate and replaced with a spring loaded hasp. 2) Completion date: 4/30/2019 3) Environmental Director responsible for correction and monitoring to prevent reoccurrence.	

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K 222	Continued From page 5 This deficient condition was confirmed by the facility Administrator and Environmental Director.	K 222		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 19 of the 102 residents and an undetermined amount of staff and visitors. Findings include:	K 341	1) The ceiling smoke detector head has been relocated in the Long Term Care Dining Room so that it is 36 inches away from the ceiling air diffuser. 2) Completion date: 5/1/2019 3) Environmental Director responsible for correction and monitoring to prevent reoccurrence.	5/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**04/30/2019**

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

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K 341	Continued From page 6 On the facility tour between 8:00 am to 12:00 pm on 04/30/2019 observations revealed a smoke detector in the main dining area by resident room 118 within 36 inches of an HVAC diffuser. This deficient condition was confirmed by the facility Administrator and Environmental Director.	K 341		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 13.7.1 item 1. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function	K 353	1) The picnic table sitting below the FDC has been removed from the Adult Day Care patio area. The access to the FDC is open. 2) Completion date: 5/1/2019	5/1/19

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**04/30/2019**

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K 353	Continued From page 7 properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/30/2019 observations revealed a picnic table blocking the Fire Department Connection (FDC). This deficient condition was confirmed by the facility Administrator and Environmental Director.	K 353	3) Environmental Director responsible for correction and monitoring to prevent reoccurrence.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 4 smoke barrier doors in accordance with the Life Safety Code (NFPA 101) 2012 edition section 101.8.5.4.1 and NFPA 80 the Standard for Fire Doors and Other Opening	K 374	1) A UL Classified Fire/Smoke seal has been added to the Transitional Care Unit hallway smoke compartment doors. 2) Completion date: 5/1/2019	5/1/19

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**04/30/2019**

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K 374	Continued From page 8 Protective's, 2010 edition, section 6.3.1.7. This deficient practice could allow the transfer of smoke from one smoke compartment to another making the corridors untenable. This condition could affect 31 of the 102 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/30/2019 observations revealed the cross corridor doors in wing 200 has a center door gap that exceeds 1/8 inch. This deficient condition was confirmed by the facility Administrator and Environmental Director.	K 374	3) Environmental Director responsible for correction and monitoring to prevent reoccurrence.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920		4/30/19

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K 920	Continued From page 9 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect and an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/30/2019 observations revealed a refrigerator plugged into a power strip in the restorative room. This deficient condition was confirmed by the facility Administrator and Environmental Director.	K 920	1) The power cord on the refrigerator located in the Restorative Nursing Room has been replaced with a longer one. The refrigerator is now plugged directly into the wall receptacle. 2) Completion date: 4/30/2019 3) Environmental Director responsible for correction and monitoring to prevent reoccurrence.	