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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KLSJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00775

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245361**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **EMMANUEL HOME**
(L4) **600 SOUTH DAVIS AVENUE**
(L5) **LITCHFIELD, MN** (L6) **55355**

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 **08/13/2014** (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 **90** (L18)

13.Total Certified Beds **90** (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
	90			
(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 :
Brenda Fischer, Unit Supervisor — 08/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 08/28/2014 (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
10/01/1986
(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
08/18/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245361

August 28, 2014

Mr. Blaine Gamst, Administrator
Emmanuel Home
600 South Davis Avenue
Litchfield, Minnesota 55355

Dear Mr. Gamst:

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 August 5, 2014 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 29, 2014

Mr. Blaine Gamst, Administrator
Emmanuel Home
600 South Davis Avenue
Litchfield, Minnesota 55355

RE: Project Number S5361023

Dear Mr. Gamst:

On July 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 26, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 11, 2014, 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 June 26, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 26, 2014, effective August 5, 2014 and therefore remedies outlined in our letter to you dated July 10, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245361	A. Building B. Wing	8/13/2014

Name of Facility	Street Address, City, State, Zip Code
EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **08/04/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/05/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/05/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/05/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	08/28/2014	10562	08/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/26/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245361	A. Building B. Wing 01 - MAIN BUILDING 01	8/11/2014

Name of Facility	Street Address, City, State, Zip Code
EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0076	Correction Completed **08/05/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **08/05/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 08/28/2014	Signature of Surveyor: 22373	Date: 08/11/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/27/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KLSJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00775

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245361**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **EMMANUEL HOME**
(L4) **600 SOUTH DAVIS AVENUE**
(L5) **LITCHFIELD, MN** (L6) **55355**

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 **06/26/2014** (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 **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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 :
Carol Bode, HFE NE II — 08/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 08/15/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
10/01/1986
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0426

July 10, 2014

Mr. Blaine Gamst, Administrator
Emmanuel Home
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number S5361023

Dear Mr. Gamst:

On June 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 5, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 5, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 26, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	00775	A. BUILDING: _____ B. WING _____	06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 23-26, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED JUL 22 2014 MN Dept of Health St.Cloud Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: _____ B. WING _____	06/26/2014

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2 000	Continued From page 1 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed rails were assessed and met the Federal Drug Administration (FDA) guidelines to reduce entrapment hazards for 1 of 1 resident (R31) whose bed rail exceeded the recommended dimensional limits. Findings include: R31's quarterly Minimum Data Set (MDS) dated 4/23/14, indicated diagnoses of hypertension and depression. The MDS also indicated R31 needed extensive assist of two with bed mobility. R31's care plan dated 2/24/14 indicated she had 1/2 bed rails to assist with repositioning her self. During observation 6/25/14, at 7:03 a.m. R31 was observed in bed with bilateral rails were in the up position. The spaces between the rails measured 7 1/4 inches by 5 1/4 inches in diameter. The Guidance for Industry and FDA Staff/Hospital Bed System Dimensional and Guidance to Reduce Entrapment Guidelines (issued 3/10/06) recommended the dimensional limit for Zone 1 (space within the bed rail) be fewer than 4 3/4 inches, to reduce the risk of head entrapment. R31's had a Functional/Safety Assessment dated 1/22/14, but there was no indication that she had bilateral half side rails. The record also had a Bed Rail Consent form dated 4/10/14 that indicated she had 1/2 bed rails used for positioning and	2 830		

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2 830	Continued From page 3 increased independence to get in and out of bed. The assessment did not identify if R31, was safe to utilize a bed that had side rails larger than the FDA recommendations to ensure bed rails were not an entrapment hazard for R31. During interview 6/25/14, at 8:14 a.m. registered nurse (RN)-B stated R31 uses her bed rails for mobility and repositioning. RN-B verified the Functional/Safety Assessment did not indicate she had bed rails, the measurements and if R31 was safe to use the bed rails. During interview 6/25/14, at 9:00 a.m. maintenance assistant stated he reviews the bed rails quarterly on the residents beds and was not aware that R31's bed rails did not meet FDA guidance for zone one recommendations. During interview 6/25/14, at 9:05 a.m. the administrator stated he was not aware that R31's bed rails did not meet FDA guidance and stated the facility will be reviewing all residents beds with rails and make sure the residents are assessed to use them safely. The facility Bed Rail policy revised May 2011 indicated bed rails are recognized as a potential safety hazard. Bed rails are only used when a assessment shows the benefit to the resident outweighs the risk of using a bed rail. The policy further indicated the person applying the bed rails to a bed checks to assure there are no gaps between the rail and the mattress or within the rail that is large enough to cause increased risk of injury. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 4 The administrator or designee could review the assessment process for resident side rails, review all resident side rails to ensure they are not an entrapment hazard, and train staff on the policies and monitor implementation of the policies. TIME PERIOD FOR CORRECTION: Five (5) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and determine medical justification for ongoing use of an indwelling urinary catheter for 1 of 1 residents (R9) in the sample who had an indwelling catheter.	2 910		

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2 910	Continued From page 5 Findings include: R9's care plan dated 4/10/13, indicated she had diagnoses of congestive heart failure and chronic renal insufficiency. The care plan also indicated she had a history of skin concerns and had a urinary catheter. R9's quarterly Minimum Data Set (MDS) dated 4/16/14 indicated she was moderately cognitively impaired and had a indwelling catheter. On 6/25/14, at 7:05 a.m. R9 was observed to be in bed with her indwelling catheter bag attached to the bottom of her bed. Review of R9's Bowel and Bladder assessment dated 8/7/13, indicated she had a catheter inserted 4/10/13, for urinary retention. A Bowel and Bladder assessment summary dated 4/23/14, indicated "The resident had catheter removed 3/2013 as skin issues stable. She had a UTI (urinary tract infection) on 4/7/13 set up bladder scans with significant retention noted and catheter replaced and will continue." Review of R9's medical record indicated there was a physician order on 4/9/13 to straight cath the resident for residual urine times two. A interdisciplinary progress note to the physician dated 4/10/13, indicated "You asked to cath resident for post void residual x 2. First one was 250 ml (milliliters) the last 100 ml of the cathed residual, was a sediment/creamy color. The second post void residual was 650 ml. Resident was incontinent... There was a mention of using a cath for her, but I am not sure where that came from, as I do not see an order from you. Resident is currently being treated for a UTI. any	2 910		

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2 910	Continued From page 6 new orders? Any changes?" A Physician Fax Order Form dated 4/10/13, indicated to leave the catheter in. Review of 9's Treatment Record indicated on 4/9/13 R9 had one 250 ml of post residual void and 4/10/13 she had one 650 ml of post residual void. The medical record did not indicate any other post residual voids had been completed since 4/10/13 to determine if the urinary catheter could be removed. During interview 6/25/14, at 1:30 p.m. Registered Nurse (RN)-C stated R9 had a indwelling catheter due to urinary retention in April 2013. RN-C indicated they had only completed two post residual voids and there has been no attempts to remove the indwelling catheter or attempts to initiate a voiding trial since the catheter was placed in April 2013. Although R9 had a indwelling catheter placed for skin breakdown, removed and reinserted due to one post residual void at 650 ml. The facility made no other attempts to remove or initiate any additional voiding trials. The facility policy Urinary Incontinence policy revised May 2011, indicated "A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible". SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could review	2 910		

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2 910	Continued From page 7 the process of nursing assessments completed to justify indwelling catheter usage. The director of nursing or designee could educate and train staff on the policy, assessment and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure upholstered chairs located in 1 of 4 dayrooms (First Street Unit) were clean and in good repair, which potentially affected 16 residents in that unit. In addition, the kitchen floor was not clean or well maintained. This had the potential to affect 85 residents who received services from the kitchen. Findings include: During an environmental tour on 6/26/14, at 10:15 a.m. with the maintenance director (MD-A) and the administrator the following was observed. There were two tan cloth upholstered chairs in the dayroom, which was located at the end of the First Street Unit. Both of these chairs had multiple tears that were approximately four inches long, that exposed the white stuffing from the chair arms. This made it difficult to clean the chairs in	21665		

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21665	Continued From page 8 this condition. The seat, back and arms of the chairs had visible dirt and debris. The upholstery on the seats of the chairs, was also worn that had an identifiable wear pattern. During interview on 6/26/14 at 10:20 a.m. the administrator and MD-A stated they would remove the chairs from the facility. During observation of the initial kitchen tour with the dietary specialist (DS)-A on 6/23/14, at 1:22 p.m. The kitchen floor was visible dirty, with a tracking pattern throughout the walkways of the kitchen. There was a heavy accumulation of dust, dirt and debris scattered under the carts and kitchen cabinets. There was a thick black, sticky substance, around multiple floor drains throughout the kitchen. During observation of the kitchen with dietary manager (DM)-A on 6/24/14, at 1:25 p.m. the floor had a visible dusty gray film that was in the walkways. There was a heavy accumulation of dust, dirt and debris scattered under the carts and kitchen cabinets. There was a thick black, sticky substance, around multiple floor drains throughout the kitchen, which was noted on 6/23/14. The DM-A stated, there was a schedule for floors to be cleaned daily including under cabinets and carts. DM-A stated the floors should have been cleaned. During observation of the kitchen on 6/25/14, at 12:15 p.m. the general walkways were mopped and clean however, there continued to be visible dirt, dust and debris under the cabinets and the floor drains were not cleaned. Cook -A stated, " I do see there is dirt but it is hard to mop under there and normally they power wash the floors monthly."	21665		

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21665	Continued From page 9 Review of the June 2014 cleaning schedule, identified the floors had been cleaned daily, and were signed off as being completed, even though there was viable dirt, dust and debris noted in these areas. Review of the facility Sanitation of Dining and Food Service Areas policy which was not dated, identified a cleaning schedules would be posted and staff would be held accountable for their completion. SUGGESTED METHOD OF CORRECTION: The administrator or designee could update facility policies and procedures related to monitoring the furniture in common areas and kitchen floor, train staff on the policies and monitor implementation of the policies. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as	21800		

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21800	Continued From page 10 provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notice of Medicare non-coverage in a timely manner to 2 of 3 residents (R16, R48) reviewed for liability notices. Findings include: R48's progress note (PN), dated 1/14/14, indicated R48 was admitted to the facility from the hospital following a congestive heart failure (CHF) exacerbation. The PN further identified that R48 was unable to progress in therapy due to dementia, "nursing rehab programs to be set-up with therapies last day being 1/16/14...Will issue expedited notice and SNFABN [Skilled Nursing Facility Advance Beneficiary Notice] for	21800		

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21800	Continued From page 11 signatures by family. Family to be notified of change insurance coverage." R48's SNFABN was signed by family on 1/17/14, one day after Medicare coverage had ended. R48 continued to remain in the facility. R16's had an liability notice form, CMS 10123, undated that identified Medicare services would end on 1/30/14. It further identified "Resident's condition is chronic and unlikely to improve so will issue expedited notice today with 1/30/14 being last covered day under Medicare guidelines... Clinical nurse to contact family with this information. Expedited and SNFABN issued for signatures." Review of the CMS 10123 form indicated an area that identified the signature of the patient or representative which was left blank. R16's also had a SNFABN form, dated 1/28/14, that identified the last covered day of Medicare would be 1/30/14 as there was no skilled care required per Medicare guidelines. The form had an area that identified the signature of the patient or of authorized representative which was blank. There was no indication family was notified with the required 48 hour notice prior to coverage termination, even though R16 continued to remain in the facility. During interview on 6/26/14 at 11:58 a.m., registered nurse (RN)-A stated the non-coverage notice for R48 was signed by family on 1/17/14, one day after Medicare coverage was terminated. RN-A stated she was not sure if the family was aware of the coverage ending, two days prior to stopping service. RN-A further stated that R16's CMS 10123 and SNFABN forms were not signed by family. RN-A provided a copy of a facility	21800		

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21800	Continued From page 12 flowsheet, dated January 2014, used for tracking purposes when a non-coverage letter was issued. The undated flowsheet indicated it was mailed for signatures, however there was no date that identified when this occurred or if the family received the notice of noncoverage prior to services ending. The facility policy Medicare Part A Determination, dated May 2011, indicated that residents "are informed of their right to receive Medicare benefits upon admission and ongoing throughout their stay, as applicable." The policy further stated a purpose to "determine Medicare Part A coverage/denial in a timely and consistent manner. To meet all Medicare mandated criteria." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive the required Medicare denial and appeal rights notices; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21800		

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F 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable 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	RECEIVED JUL 2 2 2014 MN Dept of Health St.Cloud	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	**F156-D---Notice of Medicare Non-coverage** **Plan of correction for residents cited with this survey:** For residents cited in this survey, the window of time to give notice of Medicare non-coverage has passed. **Measures put into place to prevent in the future:** 1. Education to all staff who issue SNFABN's for non-coverage of Medicare on July 21st, 2014 regarding:	8-4-14

8/4/14 IA accepted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blaine Gamsa — TITLE: Executive Director — (X6) DATE: 7/18/14

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
	245361	A. BUILDING _____ B. WING _____	06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(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 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	a. All SNFABN's that are unable to be signed on the correct date per CMS rules will be sent for signature via certified mail once a verbal notice has been given. b. All verbal and written notifications will be documented in the resident record at the time of notification. **Plans to Monitor Performance:** 1. Date compliance audit for 100% of SNFABN's issued for 1 month, then 10% of SNFABN's will have a date compliance audit for 3 months, then may discontinue audits at the recommendation of the QAPI committee.	

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notice of Medicare non-coverage in a timely manner to 2 of 3 residents (R16, R48) reviewed for liability notices. Findings include: R48's progress note (PN), dated 1/14/14, indicated R48 was admitted to the facility from the hospital following a congestive heart failure (CHF) exacerbation. The PN further identified that R48 was unable to progress in therapy due to dementia, "nursing rehab programs to be set-up with therapies last day being 1/16/14...Will issue expedited notice and SNFABN [Skilled Nursing Facility Advance Beneficiary Notice] for signatures by family. Family to be notified of change insurance coverage." R48's SNFABN	F 156	**The Director of Nursing will be responsible to ensure that the facility remains compliant in this area.** **This deficiency will be corrected by Monday August 4th, 2014.**	

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F 156	Continued From page 3 was signed by family on 1/17/14, one day after Medicare coverage had ended. R48 continued to remain in the facility. R16's had an liability notice form, CMS 10123, undated that identified Medicare services would end on 1/30/14. It further identified "Resident's condition is chronic and unlikely to improve so will issue expedited notice today with 1/30/14 being last covered day under Medicare guidelines... Clinical nurse to contact family with this information. Expedited and SNFABN issued for signatures." Review of the CMS 10123 form indicated an area that identified the signature of the patient or representative which was left blank. R16's also had a SNFABN form, dated 1/28/14, that identified the last covered day of Medicare would be 1/30/14 as there was no skilled care required per Medicare guidelines. The form had an area that identified the signature of the patient or of authorized representative which was blank. There was no indication family was notified with the required 48 hour notice prior to coverage termination, even though R16 continued to remain in the facility. During interview on 6/26/14 at 11:58 a.m., registered nurse (RN)-A stated the non-coverage notice for R48 was signed by family on 1/17/14, one day after Medicare coverage was terminated. RN-A stated she was not sure if the family was aware of the coverage ending, two days prior to stopping service. RN-A further stated that R16's CMS 10123 and SNFABN forms were not signed by family. RN-A provided a copy of a facility flowsheet, dated January 2014, used for tracking	F 156		

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F 156	Continued From page 4 purposes when a non-coverage letter was issued. The undated flowsheet indicated it was mailed for signatures, however there was no date that identified when this occurred or if the family received the notice of noncoverage prior to services ending. The facility policy Medicare Part A Determination, dated May 2011, indicated that residents "are informed of their right to receive Medicare benefits upon admission and ongoing throughout their stay, as applicable." The policy further stated a purpose to "determine Medicare Part A coverage/denial in a timely and consistent manner. To meet all Medicare mandated criteria."	F 156		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and determine medical justification for ongoing use of an indwelling urinary catheter for 1	F 315	**F315-D Indwelling Catheter-trial reduction** **Plan of correction for residents cited with this survey:** 1. We received orders from the physician on 6/26/14 to complete a trial removal of the catheter and reinsert if resident has residuals greater than 100cc. Resident does not wish to try intermittent catheterization.	

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F 315	Continued From page 5 of 1 residents (R9) in the sample who had an indwelling catheter. Findings include: R9's care plan dated 4/10/13, indicated she had diagnoses of congestive heart failure and chronic renal insufficiency. The care plan also indicated she had a history of skin concerns and had a urinary catheter. R9's quarterly Minimum Data Set (MDS) dated 4/16/14 indicated she was moderately cognitively impaired and had a indwelling catheter. On 6/25/14, at 7:05 a.m. R9 was observed to be in bed with her indwelling catheter bag attached to the bottom of her bed. Review of R9's Bowel and Bladder assessment dated 8/7/13, indicated she had a catheter inserted 4/10/13, for urinary retention. A Bowel and Bladder assessment summary dated 4/23/14, indicated "The resident had catheter removed 3/2013 as skin issues stable. She had a UTI (urinary tract infection) on 4/7/13 set up bladder scans with significant retention noted and catheter replaced and will continue." Review of R9's medical record indicated there was a physician order on 4/9/13 to straight cath the resident for residual urine times two. A interdisciplinary progress note to the physician dated 4/10/13, indicated "You asked to cath resident for post void residual x 2. First one was 250 ml (milliliters) the last 100 ml of the cathed residual, was a sediment/creamy color. The second post void residual was 650 ml. Resident was incontinent... There was a mention of using a	F 315	**Measures put into place to prevent in the future:** 1. Education to RN managers on 7/21/14 regarding urinary incontinence policy. 2. All residents who currently have indwelling catheters in place will be assessed to determine if they are appropriate to discontinue or utilize intermittent catheterization vs indwelling catheter. 3. For all residents utilizing an indwelling catheter, RN Manager will assess quarterly the appropriateness of continuing with an indwelling catheter.	

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F 315	Continued From page 6 cath for her, but I am not sure where that came from, as I do not see an order from you. Resident is currently being treated for a UTI. any new orders? Any changes?" A Physician Fax Order Form dated 4/10/13, indicated to leave the catheter in. Review of 9's Treatment Record indicated on 4/9/13 R9 had one 250 ml of post residual void and 4/10/13 she had one 650 ml of post residual void. The medical record did not indicate any other post residual voids had been completed since 4/10/13 to determine if the urinary catheter could be removed. During interview 6/25/14, at 1:30 p.m. Registered Nurse (RN)-C stated R9 had a indwelling catheter due to urinary retention in April 2013. RN-C indicated they had only completed two post residual voids and there has been no attempts to remove the indwelling catheter or attempts to initiate a voiding trial since the catheter was placed in April 2013. Although R9 had a indwelling catheter placed for skin breakdown, removed and reinserted due to one post residual void at 650 ml. The facility made no other attempts to remove or initiate any additional voiding trials. The facility policy Urinary Incontinence policy revised May 2011, indicated "A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible".	F 315	a. If a resident is appropriate for a reduction, the RN manager will address with the physician and resident the possibility of utilizing intermittent catheterization vs indwelling when a catheter is indicated and will follow physician recommendations and resident wishes. **Plans to Monitor Performance:** 1. Will complete 100% audit of bladder assessments for residents who have catheters x1 month, then will complete 100% audit of bladder assessments for residents who have catheters quarterly x 1 quarter, then 10% of bladder assessments for residents who have catheters quarterly. May discontinue the audits at the recommendation of the QAPI committee.	

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F 323 F 323 SS=D	Continued From page 7 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed rails were assessed and met the Federal Drug Administration (FDA) guidelines to reduce entrapment hazards for 1 of 1 resident (R31) whose bed rail exceeded the recommended dimensional limits. Findings include: R31's quarterly Minimum Data Set (MDS) dated 4/23/14, indicated diagnoses of hypertension and depression. The MDS also indicated R31 needed extensive assist of two with bed mobility. R31's care plan dated 2/24/14 indicated she had 1/2 bed rails to assist with repositioning her self. During observation 6/25/14, at 7:03 a.m. R31 was observed in bed with bilateral rails were in the up position. The spaces between the rails measured 7 1/4 inches by 5 1/4 inches in diameter. The Guidance for Industry and FDA Staff/Hospital Bed System Dimensional and Guidance to Reduce Entrapment Guidelines (issued 3/10/06) recommended the dimensional limit for Zone 1	F 323 F 323	**The Director of Nursing will be responsible to ensure that the facility remains compliant in this area.** **This deficiency will be corrected by August 5th, 2014.** **F323-D---Assess for safety of side rails** **Plan of correction for residents cited with this survey:** 1. Resident assessed for appropriateness of side rail use. 2. Side rail that meets the FDA Hospital bed guidance to reduce entrapment guidelines placed on 6/25/14. **Measures put into place to prevent in the future:** **1.** 100% audit of all side rails to determine if meets the FDA Hospital bed guidance to reduce entrapment guidelines completed on 6/26/14.	

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EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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F 323	Continued From page 8 (space within the bed rail) be fewer than 4 3/4 inches, to reduce the risk of head entrapment. R31's had a Functional/Safety Assessment dated 1/22/14, but there was no indication that she had bilateral half side rails. The record also had a Bed Rail Consent form dated 4/10/14 that indicated she had 1/2 bed rails used for positioning and increased independence to get in and out of bed. The assessment did not identify if R31, was safe to utilize a bed that had side rails larger than the FDA recommendations to ensure bed rails were not an entrapment hazard for R31. During interview 6/25/14, at 8:14 a.m. registered nurse (RN)-B stated R31 uses her bed rails for mobility and repositioning. RN-B verified the Functional/Safety Assessment did not indicate she had bed rails, the measurements and if R31 was safe to use the bed rails. During interview 6/25/14, at 9:00 a.m. maintenance assistant stated he reviews the bed rails quarterly on the residents beds and was not aware that R31's bed rails did not meet FDA guidance for zone one recommendations. During interview 6/25/14, at 9:05 a.m. the administrator stated he was not aware that R31's bed rails did not meet FDA guidance and stated the facility will be reviewing all residents beds with rails and make sure the residents are assessed to use them safely. The facility Bed Rail policy revised May 2011 indicated bed rails are recognized as a potential safety hazard. Bed rails are only used when a assessment shows the benefit to the resident	F 323	**2.** 100% audit of all side rails in storage will be completed; any rails found out of compliance will be disposed of. **3.** All residents with a side rail currently in use will be reassessed for appropriateness of use. **4.** All residents with a side rail in use will be reassessed at minimum quarterly to determine continued need for their side rail. **Plans to Monitor Performance:** 1. 100% audit of all side rails to determine if meets the FDA Hospital bed guidance to reduce entrapment guidelines completed on 6/26/14.	

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F 323	Continued From page 9 outweighs the risk of using a bed rail. The policy further indicated the person applying the bed rails to a bed checks to assure there are no gaps between the rail and the mattress or within the rail that is large enough to cause increased risk of injury.	F 323	2. Random audit of 20% of all residents utilizing side rails on a monthly basis x 3months then a quarterly basis until recommendation to d/c from the QAPI committee to ensure: a. Compliance with FDA Hospital bed guidance to reduce entrapment guidelines b. Compliance with assessment on a quarterly basis to ensure side rails continue to be appropriate. The Director of Nursing will be responsible to ensure that the facility remains compliant in this area. **This deficiency will be corrected by August 5th, 2014.**	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure upholstered chairs located in 1 of 4 dayrooms (First Street Unit) were clean and in good repair, which potentially affected 16 residents in that unit. In addition, the kitchen floor was not clean or well maintained. This had the potential to affect 85 residents who received services from the kitchen. Findings include: During an environmental tour on 6/26/14, at 10:15 a.m. with the maintenance director (MD-A) and the administrator the following was observed. There were two tan cloth upholstered chairs in the dayroom, which was located at the end of the First Street Unit. Both of these chairs had multiple tears that were approximately four inches long, that exposed the white stuffing from the chair arms. This made it difficult to clean the chairs in this condition. The seat, back and arms of the	F 465		

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F 465	Continued From page 10 chairs had visible dirt and debris. The upholstery on the seats of the chairs, was also worn that had an identifiable wear pattern. During interview on 6/26/14 at 10:20 a.m. the administrator and MD-A stated they would remove the chairs from the facility. During observation of the initial kitchen tour with the dietary specialist (DS)-A on 6/23/14, at 1:22 p.m. The kitchen floor was visible dirty, with a tracking pattern throughout the walkways of the kitchen. There was a heavy accumulation of dust, dirt and debris scattered under the carts and kitchen cabinets. There was a thick black, sticky substance, around multiple floor drains throughout the kitchen. During observation of the kitchen with dietary manager (DM)-A on 6/24/14, at 1:25 p.m. the floor had a visible dusty gray film that was in the walkways. There was a heavy accumulation of dust, dirt and debris scattered under the carts and kitchen cabinets. There was a thick black, sticky substance, around multiple floor drains throughout the kitchen, which was noted on 6/23/14. The DM-A stated, there was a schedule for floors to be cleaned daily including under cabinets and carts. DM-A stated the floors should have been cleaned. During observation of the kitchen on 6/25/14, at 12:15 p.m. the general walkways were mopped and clean however, there continued to be visible dirt, dust and debris under the cabinets and the floor drains were not cleaned. Cook -A stated, " I do see there is dirt but it is hard to mop under there and normally they power wash the floors monthly."	F 465	**F465-E---Sanitary Environment-KITCHEN/Furniture** **Plan of correction for residents cited with this survey:** Although no specific residents are cited in this deficiency, immediate corrective action was taken by removing furniture in disrepair and by educating staff on proper floor care. **Measures put into place to prevent in the future:** 1. Training and education provided to all dietary staff on proper floor care procedure July 14th, 2014. Training information sent July 16th, 2014 for staff unable to attend. 2. Maintenance will power scrub the kitchen floor on a quarterly routine. 3. A Maintenance Quarterly floor cleaning schedule was created on July 14th, 2014.	

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F 465	Continued From page 11 Review of the June 2014 cleaning schedule, identified the floors had been cleaned daily, and were signed off as being completed, even though there was viable dirt, dust and debris noted in these areas. Review of the facility Sanitation of Dining and Food Service Areas policy which was not dated, identified a cleaning schedules would be posted and staff would be held accountable for their completion.	F 465	4. Facility maintenance staff will conduct a quarterly inspection of all furniture and remove any items in disrepair. 5. Nursing staff education to notify maintenance of furniture found in disrepair. 1. Weekly audits on floor cleanliness will be completed once weekly for three months then Monthly. Will discontinue audits upon recommendation from the QAPI committee. 2. Facility maintenance staff will conduct a quarterly inspection of all furniture and remove any items in disrepair. This task will be added to their preventative maintenance routine. **This deficiency will be corrected by August 5th, 2014.** **Director of Maintenance will be responsible to ensure that the facility remains compliant in this area.**	

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

F5361023

PRINTED: 07/10/2014
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
	245361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT 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, State Fire Marshal Division, on June 27, 2014. At the time of this survey, Emmanuel Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF 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 55101-5145, or	K 000	POC ok FB 1-22-14 RECEIVED JUL 18 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 8-5-14
EXIT: 6-26-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blaine Donner
TITLE: Executive Director
(X6) DATE: 7/18/14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(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
K 000	Continued From page 1 By eMail to: Marian.Whitney@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. Emmanuel Home is a one-story building with partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 86 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**K076** 1. The unsecure oxygen cylinder was immediately placed in the secure oxygen storage location. Education regarding proper oxygen storage was provided to staff at a monthly fire drill on 6/27/14. Education on proper oxygen cylinder storage provided at mandatory nursing assistant meeting on 7/17/14. Education was provided to all nursing staff regarding proper storage of oxygen tanks on 7/18/14. 2. Date of completion: August 5, 2014 3. Director of Nursing will be responsible for correction and monitoring to prevent reoccurrence. Education will be provided at monthly fire drills. Audits will be conducted. Daily x 1 week, Weekly x 1 month, and Monthly until discontinued by QAPI committee.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.	K 076		

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K 076	Continued From page 2 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility was storing a medical gas cylinder in a manner not in conformance with the requirements at NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1. This deficient practice could adversely affect 12 of 90 residents in the vicinity of the North Nurse's Station. FINDINGS INCLUDE: On 06/27/2014 at 1:20 PM, observation revealed one (1) empty oxygen cylinder stored on the floor surface, adjacent to the North Nurse's Station. The oxygen cylinder was standing in an upright position, and was not secured and located to prevent tipping/falling. This free-standing storage arrangement was not in conformance with the requirements at NFPA 99 (1999), Chapter 4, Section 4-3.1.1.1 and Chapter 8, Section 8-3.1.1. This finding was confirmed with the facility administrator at the time of discovery.	K 076		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 144	**K 144** 1. Facility Director of Maintenance has scheduled a load bank test to be completed before August 5th. Generators will be inspected weekly and exercised and documented in accordance with NFPA guidelines. 2. Date of completion: August 5, 2014 3. Facility Director of Maintenance will be responsible for correction and prevention of future occurrence.	

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K 144	Continued From page 3 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. In a fire or other emergency, this deficient practice could adversely affect 90 of 90 residents, staff and visitors. FINDINGS INCLUDE: On 06/27/2014 at 12:15 PM, during a review of the emergency generator monthly inspection and testing logs for the previous year, the percent of load (KW) had not been recorded. As such, it could not be documented that the genset had been either: 1). Exercised at not less than 30% of the EPS nameplate rating, or; 2). Loaded to maintain the minimum exhaust gas temperature as recommended by the manufacturer, or; 3). Had a 2-hour load bank test performed within the previous year. This finding was confirmed with the chief building engineer.	K 144		

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