### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL E SURVEY AGENCY		ecility ID: 00013
MEDICARE/MEDICAID PROVIDER N     (L1) 245489 2.STATE VENDOR OR MEDICAID NO.     (L2) 726040700 5. EFFECTIVE DATE CHANGE OF OWN     (L9)		<ol> <li>NAME AND ADI (L3) EMMANUEI (L4) 1415 MADIS<sup>6</sup> (L5) DETROIT L<sup>2</sup></li> <li>PROVIDER/SUF 01 Hospital</li> </ol>	L NURSING HOM ON AVENUE AKES, MN	ЛЕ	(L6) <b>56501</b> <u>02</u> (L7) 13 PTIP 22 CLIA	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Con	Z_(L8)         2. Recertification         4. CHOW         6. Complaint         9. Other         nplaint
6. DATE OF SURVEY 05/28 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING I 09/30	DATE: (L35)
<ul> <li>11. LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWN</li> </ul>	<ul><li>112 (L18)</li><li>112 (L17)</li></ul>	B. Not in Com	ce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A 15. FACILITY MEETS	6. Scope of Servic 7. Medical Directo	)r
18 SNF 18/19 SNF 112 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):	I			
17. SURVEYOR SIGNATURE			06/12/2014	(L19)	18. STATE SURVEY AGENCY AP Enforcement S	Specialist	Date: 07/31/2014 (L20)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>_X_ 1. Facility is Eligible to Part</li> <li> 2. Facility is not Eligible</li> </ol>		20. COM	IPLIANCE WITH CI		21. 1. Statement of Financi	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-	-1513)
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI	DATE	4. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimbursemen         03-Risk of Involuntary Termination	05-Fail to Me	et Health/Safety
(L27)	A. Suspension o B. Rescind Susp		(L44) (L45)		04-Other Reason for Withdrawal	07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS Posted 08/01/2014 (	Co.	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION C 05/30/2014	DF APPROVAL DAT	Е (L33)	DETERMINATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5489

June 17, 2014

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

Dear Ms. Green:

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

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

Effective May 14, 2014 the above facility is certified for:

112 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 112 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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



### Protecting, Maintaining and Improving the Health of Minnesotans

June 12, 2014

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

RE: Project Number S5489022

Dear Ms. Green:

On April 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 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 May 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2014, effective May 14, 2014 and therefore remedies outlined in our letter to you dated April 24, 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 related to this eNotice.

Sincerely,

## Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File 5489r14.rtf General Information: (651) 201-5000 \* TDD/TTY: (651) 201-5797 \* Minnesota Relay Service: (800) 627-3529 \* www.health.state.mn.us For directions to any of the MDH locations, call (651) 201-5000 \* An Equal Opportunity Employer

### **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.

( )	Provider / Supplier / CLIA / Identification Number 245489	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/28/2014
Name o	of Facility		Street Address, City, State, Zip Code	
EMN	MANUEL NURSING HOME		1415 MADISON AVENUE DETROIT LAKES, MN 56501	

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

(Y4) Item	(Y5	) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	F0241	Correction Completed 05/14/2014	ID Prefix	F0371	Correction Completed 05/14/2014	ID Prefix		Correction Completed
Reg. # LSC	483.15(a)	-	Reg. # LSC	483.35(i)		Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed 	Reg. #		Correction Completed	ID Prefix		Correction Completed
ID Prefix Reg. # LSC		Correction Completed 	Reg. #		Correction Completed	Reg. #		
ID Prefix Reg. # LSC			Reg. #					
ID Prefix Reg. # LSC		_	Reg. #					
Reviewed By		-	Date:	Signature of Surve	-		Dat	
State Agency Reviewed By			06/12/20	14 Signature of Surve	3260	3	Dat	05/28/2014
CMS RO		_,			,			
Followup to	Survey Completed on: 4/10/2014					eficiencies. Was a (CMS-2567) Sent to	the Feeility?	ES NO



Protecting, Maintaining and Improving the Health of Minnesotans

June 12, 2014

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

Re: Enclosed Reinspection Results - Project Number S5489022

Dear Ms. Green:

On May 28, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 10, 2014, with orders received by you on May 1, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5489r14.rtf

### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00013	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/28/2014		
Name	of Facility		Street Address, City, State, Zip Code			
EM	MANUEL NURSING HOME		1415 MADISON AVENUE DETROIT LAKES, MN 56501			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	()	5) Date	(Y4) Ite	em	(Y5)	Date	(Y4) Item		(Y5)	Date
		Correction				Correction				Correction
		Completed				Completed		_		Completed
ID Prefix		05/28/2014			21805	05/28/2014	ID Pret			
-	MN Rule 4658.0610 Sub	<b>b.</b> 7	F	•	MN St. Statute 144.651 Su	bd. 5	Reg.			
LSC		_		LSC			LS	C		_
		Correction				Correction				Correction
		Completed				Completed				Completed
ID Prefix			ID	Prefix			ID Pret	ïx		
Reg. #				Reg. #			Reg.	#		
				LSC		-	LS	c		
		Correction				Correction				Correction
ID Prefix		Completed		Prefix		Completed	ID Pret	ïx		Completed
						_				
Reg. # LSC				Reg. # LSC		-	Reg.	# C		
	-					-				
		Correction				Correction				Correction
		Completed				Completed				Completed
ID Prefix			ID	Prefix		-	ID Pret	ïx		_
Reg. #			F	Reg. #		-	Reg.			
LSC		_		LSC		-	LS	C		_
		Correction				Correction				Correction
		Completed				Completed				Completed
ID Prefix		•	ID	Prefix		-	ID Pret	ïx		
Reg. #			F	Reg. #			Reg.	#		
LSC				LSC			LS	C		_
Reviewed By		•	Date:		Signature of Surve	eyor:			Date:	
State Agency	, MM/	GA	06/12	2/201	4 32	603			05/2	8/2014
Reviewed By	/ Reviewe	d By	Date:		Signature of Surve	eyor:			Date:	
CMS RO										
Followup to	Survey Completed on:				Check for any	Uncorrected D	Deficiencies. W	as a Summary of		
	4/10/2014				Uncorrecte	d Deficiencies	(CMS-2567) Se	nt to the Facility?	YES	NO
STATE FORM	I: REVISIT REPORT	(5/99)			Page 1 of 1			Event ID:	KPNL12	

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: KPNL
	PART I -	TO BE COMPL	ETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00013
1. MEDICARE/MEDICAID PROVIDE (L1) 245489	R NO.	3. NAME AND AD (L3) <b>EMMANUE</b>	L NURSING H	HOME		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 726040700	Э.	(L4) <b>1415 MADIS</b> (L5) <b>DETROIT L</b>			(L6) <b>56501</b>	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 04/10/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS		1
From (a):		A. In Complian		10.	And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	<b>112</b> (L18)		e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>IF)8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13. Total Certified Beds	<b>112</b> (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Applic		* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS	
18 SNF 18/19 SNF 112	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Tammy Williams, H	FE NEII	0.	5/16/2014	(L19)	Mark Meath	, Enforcement Specialist 05/27/2014 (L20)
PAR	T II - TO BE	COMPLETED B	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILI</li> <li>1. Facility is Eligible to Pa</li> </ol>			PLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)				5. Bour of the Above	···
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>01/01/1987</b>	BEGINNING	<b>G</b> DATE	ENDING DAI	ГЕ	VOLUNTARY         00           01-Merger, Closure         0	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	A. Suspension	n of Admissions:	<i>σ</i> . ( )		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

### CCN: 24-5489

On April 10, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7011 2000 0002 5143 7531

April 24, 2014

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

RE: Project Number S5489022

Dear Ms. Green:

On April 10, 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

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

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

## DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858

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

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 20, 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 May 20, 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

Emmanuel Nursing Home April 24, 2014 Page 4 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 July 10, 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 October 10, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action

Emmanuel Nursing Home April 24, 2014 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 related to this letter.

Emmanuel Nursing Home April 24, 2014 Page 6

Sincerely,

## Monh Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5489s14.rtf

PRINTED: 04/24/2014 FORM APPROVED

NU PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		COMP	SURVEY LETED
		245489	B. WING		04/	10/2014
NAME OF P	ROVIDER OR SUPPLIER		1	ET ADDRESS, CITY, STATE, ZIP CODE MADISON AVENUE		
EMMANUE	EL NURSING HOME		DET	ROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	F-241		(X5) COMPLETION DATE
				The one resident observe	ed —	
F 000	INITIAL COMMENTS	5	F 000	was wearing a transfer b	elt	
1 000				while dining on the mem	iory	
1	The facility's plan of	correction (POC) will corve		care unit has been obser	ved	
	as your allegation of	correction (POC) will serve		to put the belt back on		
		ance. Your signature at the		during the meal. The bel	t ic	
		ge of the CMS-2567 form will		now always removed by		
	be used as verificatio					
	•			and it is placed behind hi	1111	
		cceptable POC an on-site		on his chair.		
	revisit of your facility	-	i i	The save plan has been		
		tial compliance with the attained in accordance with		The care plan has been		
	your verification.	attained in accordance with		updated to reflect his sta		
F 241	483.15(a) DIGNITY A	ND RESPECT OF	F 241	desire to not have the be	elt	
SS=D	INDIVIDUALITY			left on during meals.		
	The facility must pror	note care for residents in a		Care giver education was	5	
		vironment that maintains or		completed by April 16, 2	014.	
		ent's dignity and respect in				
	full recognition of his	or her individuality.		Random audits througho	out	
				the nursing home have b	een	
	This REOLIREMENT	is not met as evidenced		completed weekly for for		
	by:	a normer as evidenced		weeks then quarterly two		
		n, interview and document		times. Compliance is	•	
	• •	led to ensure a dignified		reported at the quarterly	<i>ι</i> Ο Λ	
	dining experience for					
	_	ransfer/gait belt during		meeting. Audits have not	ι	
	meals in the memory	unit.		identified any residents		N'a
	Findings include:			having a transfer belt on	A	$hV \cdot I$
				during meals or activities	s. (	11 and
		m Data Set (MDS) dated			Ń	1211
		had diagnoses which		Responsible for ongoing	. n0	Ψ~ k
ľ	included dementia, se			compliance: DON and RN	I Um	l a fi
		IDS identified R70 had		managers.		1111
	severe cognitive impa	to complete all activities of				SIV
	daily living (ADL). Re			Completion Date: May 14	4,	
	······	······		2014.		
BORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE	65	(X6) DATE
	anot .	Green Sxri	TATO	- Drecton	05/	07/14

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.

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

Event ID: KPNL11

Facility ID: 00013

RECENTE Duation sheet Page 1 of 7

MAY 1 2 2014 MN Dept of Health Fergus Falls

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 04/24/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMP	
		245489	B. WING			04/	10/2014
	Rovider or supplier			1	STREET ADDRESS, CITY, STATE, ZIP CODE 415 MADISON AVENUE DETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	was disoriented, utiliz transfers, and ambula use of the gait belt an care plan, revised 4/8 assistance of one sta staff to utilize a gait be ambulation for R70. During observation of from 6:00 p.m. to 6:37 table in the small mer male residents were se same area. R70 had a with red and blue strip waist. The white stripp fastened around R700 meal. At 6:31 p.m. reg assisted R70 to ambu transfer into the recline to sit in his recliner, si striped transfer belt fro During observation or 8:37 a.m., R70 was se memory unit small dir residents, eating the to white striped transfer waist. At 7:39 a.m., R repeatedly pulled on t transfer belt. At 8:00 a the transfer belt remai waist. The white strip	4, revealed R70 had ided paranoid htia, and obsessive The summary identified R70 ed a transfer belt for all ited with assistance and the d walker. Review of the /14 directed extensive ff for ADL's, and directed elt with transfers and the supper meal on 4/7/14, I p.m., R70 was seated at a mory unit dining area. Two seated at R70's table, and eated at another table in the a white cloth transfer belt, bes, fastened around R70's ed transfer belt remained s waist during the entire gistered nurse (RN)-B late to his room and er. After RN-B assisted R70 he removed the white om his wait. 1 4/9/14, from 7:32 a.m. to eated at a table in the hing area with other oreakfast meal. R70 had a belt fastened around his 70 reached up and he buckle and strap of the a.m., R70 resumed eating, ined fastened around his ed transfer belt remained s waist during the entire	F	241			

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

Event ID: KPNL11

Facility ID: 00013

If continuation sheet Page 2 of 7

SHATE-BARNER OF DEFICIENCIES AND PLAN OF CORRECTION         (N) PROVIDER OR SUPPLIER UIDENTIFICATION NUMBER:         (P3) DATE SUPPLY COMPLETED CONFICTED         (P3) DATE SUPPLY COMPLETED           NME OF PROVIDER OR SUPPLIER         245489         N/WRO         04/10/2014           NME OF PROVIDER OR SUPPLIER         317825-289 CODE H115 MADSON AVENUE DETEOR OF LAKES, MY 66001         04/10/2014           PAGE         STREET ADDRESS, CITY, STATE, 2P CODE H115 MADSON AVENUE DETEOR OF LAKES, MY 66001         06/10/2014           PAGE         STREET ADDRESS, CITY, STATE, 2P CODE H115 MADSON AVENUE DETEOR OF LAKES, MY 66001         00/10/2014           PAGE         STREET ADDRESS, CITY, STATE, 2P CODE H115 MADSON AVENUE DETEOR CALL         00/10/2014           PAGE         STREET ADDRESS, CITY, STATE, 2P CODE H115 MADSON AVENUE DETEOR AT ADD AN AND STATE STREET ADDRESS DETEOR AT ADD AND AND STATE ADDRESS DET AND CALL DETEOR AT ADDRESS DET AND CALL         00/10/2014           PAGE         STREET ADDRESS, CITY, STATE, 2P CODE H115 MADSON AVENUE DETEOR AT ADDRESS DET ADDRESS DE ADDRESS DET ADDRESS D	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STARE, 28° CODE 1415 MADSON AVENUE       EMMANUEL NURSING HOME     DETROT LARCES, NN 55631       00-10. PROD PROD PROD PROD PRODUCTION USED FOR THE THE INFORMATION     D PRODUCTESS, NN 55631       F 241     Continued From page 2 (NA)-A assisted R70 back to his room to go to the bathroom, At 6.49 a.m. R70 was sitting in his reciliner in his room and the transfer belt was observed hanging on his walker in front of him.     F 241       During observation on 4/9/14, from 12:00 p.m. to 12:31 p.m., R70 was seated at a table with other residents in the memory unit small dining room, eating lunch. Again, R70 had the white striped transfer belt fastened to his waikt. For the entre observation period. At 12:31 p.m., a facility staff member assisted 70 back to his room, to lie down in bed. The transfer belt was removed at that time.       On 4/9/14 at 12:34 p.m. social services (SS)-A indicated she routinely assisted with meals and confirmed R70 routinely wore the transfer belt fastened to his waikt. She confirmed staff did not remove the transfer belt during meals and confirmed R70 routinely wore the transfer shelt fastened to his waikt. She confirmed staff did not termove the transfer belt during meals and confirmed R70 routinely wore the transfer shelt fastened to his waikt. She confirmed staff did not know why he wore the while striped belt during meal lines, and stald "10 on "10 hild hild thing from, they just leave if on" and indicated hat he did not know why he wore the while striped belt during meals.       On 4/9/14 at 12:30 p.m. R70 he indicated hat he did not know why he wore the while striped belt during meals.       On 4/9/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a tansfer belt he should'n have it on during meals b	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 1 1				
EMMANUEL NURSING HOME     1415 MADISON AVENUE DETROT LAKES, NN 5501       PHETRY TAG     SIMAMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECT PLAN OF CORRECTION (EACH CORRECT PLAN OF CORRECTION (EACH CORRECT PLAN OF CORRECTION) (EACH CORRECT PLAN OF CORRECT PLAN (EACH CORRECT PLAN OF COR			245489	B. WING			04/	10/2014
EMMANUEL NURSING HOME     DETROIT LAKES, NN 66691       (M) ID PHEFIX TAG     ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PREDICT WITH RECULATORY OR LS DEVIFYING NRTORMATION)     IPROTIL LAKES, NN 66691       F241     Continued From page 2 (NA)-A assisted R70 back to his room to go to the bathroom. At 8.49 a.m. R70 was stilling in his recliner in his room and the transfer belt was observed hanging on his walker in front of him.     F241       During observation on 4/9/14, from 12:00 p.m. to 12:31 p.m. R70 was seted at at able with other residents in the memory unit small dining room, eating lunch. Again, R70 had the wals, for the entire observation period. At 12:31 p.m., a facility staff member assisted R70 back to his room, to lie down in bed. The transfer belt was removed at that time.       On 4/9/14 at 12:34 p.m. social services (SS)-A indicated she routinely assisted with meals and confirmed R70 routinely to ret the during meals and confirmed R70 routinely wore the transfer belt fastened to his waist. She confirmed staff did not romove the transfer belt during meals and confirmed R70 routinely wore the transfer belt fastened to hik waist. She confirmed staff did not routinely tensine with at 12:31 p.m. R70 he indicated that he did not know why he wore the while striped belt during meals and confirmed staff did not routinely remove the transfer belt fastened to hik striped belt during meals.       On 4/9/14 at 12:30 p.m. R70 he indicated that he did not know why he wore the while striped belt during meals.       On 4/9/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a transfer belt fastered to his waist during meals he cause it in during meals.	NAME OF PI	ROVIDER OR SUPPLIER						
PRETX TVG       CALL       PRETX RECULTORY OR LSC DEMINING NFORMATION)       PRETX TVG       CALL CORRECTION ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE DEFICIENCY       COMPRETING DEFICIENCY         F 241       Continued From page 2 (NA)-A assisted R70 back to his from to go to the bathroom. At 8:49 a.m. R70 was stilling in his recliner in his room and the transfer belt was observed hanging on his walker in front of him.       F 241       F 241         During observation on 4/8/14, from 12:00 p.m. to 12:31 p.m., R70 was seated at a table with other residents in the memory unit small dining room, eating lunch. Again, R70 had the white striped transfer belt fastened to his waist, for the entire observation period. At 12:31 p.m., a facility staff member assisted R70 back to his from, to lie down in bed. The transfer belt was removed at that time.       On 4/8/14 at 12:34 p.m. social services (SS)-A indicated she routinely assisted with meals and confirmed R70 routinely assisted furing meals for R70.       On 4/8/14 at 12:35 p.m. licensed practical nurse (LPN)-A confirmed R70 routinely wore the transfer/gait belt during meal time.       On 4/8/14 at 12:37 p.m. R70 he indicated hat he did not know with wore the white striped belt during meal times, and stated T in ort like it on, they just leave it on "and indicated hat he did not know with wore the white striped belt during meals.       On 4/8/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a transfer belt fastened to his waist during meals. RNA stated "he should'h have it on during meals because it       On 4/8/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a transfer belt fastened to his waist during meals. RNA stated "he should'h have it on during meals because it       On 4/8/14 at 12:40 p.m. registered n	EMMANU	EL NURSING HOME						
<ul> <li>(NA)-A assisted R70 back to his room to go to the bathroom. At 8:49 a.m. R70 was sitting in his recliner in his room and the transfer belt was observed hanging on his walker in front of him.</li> <li>During observation on 4/9/14, from 12:00 p.m. to 12:31 p.m., R70 was seated at table with other residents in the memory unit small dhing room, eating lunch. Again, R70 had the white striped transfer belt fastened to his waist, for the entire observation period. At 12:31 p.m., a facility staff member assisted R70 back to his room, to lie down in bed. The transfer belt was removed at that time.</li> <li>On 4/9/14 at 12:34 p.m. social services (SS)-A indicated she routinely assisted with meals and confirmed R70 routinely at his mals with a transfer belt fastened to his waist. She confirmed staff did not remove the transfer belt during meals and confirmed R70 routinely wore the transfer belt during meals and confirmed R70 routinely memore the transfer jait belt during meal time.</li> <li>On 4/9/14 at 12:37 p.m. R70 he indicated that he did not know why he wore the while striped belt during meals and confirmed R70 routinely wore a transfer belt would like it off during meals.</li> <li>On 4/9/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a transfer belt have to during meals.</li> <li>On 4/9/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a transfer belt have it on during meals.</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
	F 241	<ul> <li>(NA)-A assisted R70</li> <li>bathroom. At 8:49 a.r.</li> <li>recliner in his room at observed hanging on</li> <li>During observation of 12:31 p.m., R70 was residents in the memeeating lunch. Again, F transfer belt fastened observation period. A member assisted R70 down in bed. The transfer belt fastened staff did not remove the for R70.</li> <li>On 4/9/14 at 12:35 p. (LPN)-A confirmed R70 routined transfer/gait belt arou and confirmed staff did transfer/gait belt durin</li> <li>On 4/9/14 at 12:37 p. did not know why here during meal times, and they just leave it on a off during meals.</li> <li>On 4/9/14 at 12:40 p. confirmed R70 routing fastened to his waist of the shouldn't have it of the shouldn't hav</li></ul>	back to his room to go to the n. R70 was sitting in his nd the transfer belt was his walker in front of him. n 4/9/14, from 12:00 p.m. to seated at a table with other ory unit small dining room, R70 had the white striped to his waist, for the entire t 12:31 p.m., a facility staff D back to his room, to lie hafer belt was removed at m. social services (SS)-A ly assisted with meals and ely ate his meals with a to his waist. She confirmed he transfer belt during meals id not routinely wore the nd his waist during meals id not routinely remove the ng meal time. m. R70 he indicated that he wore the white striped belt od stated "I don't like it on, and indicated he would like it m. registered nurse (RN)-A ely wore a transfer belt during meals. RN-A stated	F	241			

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

Facility ID: 00013

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STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		245489	B. WING		04/10/2014
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
EMMANU	EL NURSING HOME			ROIT LAKES, MN 56501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 241	Continued From pag	je 3	F 241		
	(DON) confirmed R7 during all meals and indicated she was no wear the belt during current care plan an facility policy. The D	o.m. the director of nursing '0 routinely wore a gait belt staff do not remove it. She ot aware R70 did not like to meals. She confirmed R70's d confirmed the current ON stated residents should during meals unless they			
F 371 SS=F	Review of the facility 11/2013, indicated s residents in a manne promotes dignity and resident and their ur 483.35(i) FOOD PR STORE/PREPARE/S	OCURE,	F 371	F-371 The outside of the oven h been sanded and painted with a high temperature appliance paint to elimina flaking and to resolve the rust spots.	ate
	considered satisfact authorities; and (2) Store, prepare, d under sanitary condi-	n sources approved or ory by Federal, State or local istribute and serve food tions T is not met as evidenced		Construction has resulted increased dust at times in the kitchen requiring additional cleaning. Periodically the kitchen h been closed for part of th day to prevent food and supplies from being expo to the dust and to allow f	as Je sed
	review, the facility fa was maintained in a for food preparation, facility. This deficien	on, interview and document iled to ensure the kitchen clean and sanitary manner storage and service in the t practice had the potential to s who were served food from		additional cleaning. Additional barriers to the kitchen entry have been added and the ceiling has been permanently closed	5

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

Facility ID: 00013

If continuation sheet Page 4 of 7

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 245489 04/10/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1415 MADISON AVENUE EMMANUEL NURSING HOME DETROIT LAKES, MN 56501 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Policies have been updated F 371 Continued From page 4 F 371 to address the need for the kitchen. additional cleaning due to Findings include: construction. On 4/9/14 at 12:14 p.m. tour of the main kitchen Residents have not been of the facility was conducted, with the dining served using any dishes, director (DD) present during the tour. During the carts or equipment that have tour the following was observed: dust on them. Additional - A Southbend brand oven was observed to have cleaning has occurred. Paper large areas of orange brown substance on the dishes have been used outside surfaces of the oven, which flaked off with throughout construction to contact to the oven. prevent breaking and - Three uncovered blue rolling carts which held cracking during transport stacks of individual white dinner plates, desert around and through the plates and cereal bowls was observed in a corner construction area. of the kitchen. A layer of whitish dirt like material was observed to cover the entire top and bottom The flat grill is not being shelf surfaces of each cart with dishes. used. - A silver colored flat grill, and on the right side of the flat grill, was a indoor black colored grate. The The brownish substance on grates on the grill had a large amount of build up the sink pipe has been of black material. In addition, the silver shelf underneath grill was covered with a thin layer of cleaned. dust and dirt particles. Staff education to ensure - A Convi brand oven on a shelf had a thin layer proper cleaning during of whitish dust and dirt particles covering both the oven and the shelf. Across from the Convi oven, construction was completed a silver sink, with exposed white drainage piping, by 4/18/14. had a large, thick layer of brownish substance on the pipe. - The large serving steam table and plate warmer had a light layer of whitish dust on it covering the surfaces. On the right side of the serving steam table was a silver colored countertop with a small FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KPNL11 Facility ID: 00013 If continuation sheet Page 5 of 7

PRINTED: 04/24/2014

CENTER	RS FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/24/2014 FORM APPROVED OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245489	B. WING		04/10/2014		
EMMANU (X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	ET ADDRESS, CITY, STATE, ZIP CODE MADISON AVENUE ROIT LAKES, MN 56501 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	ORRECTION (X5) DN SHOULD BE COMPLETION		
тад F 371	Continued From page black microwave sittin thin layer of dust cover microwave. On 4/9/14, at 12:30 p had a construction pri outside of the kitchen increased dust in the construction project s had a cleaning sched the kitchen and confir equipment and disher equipment used, nee- use because of the co confirmed the equipment	ng on it, which also had a ering the surfaces of the .m. DD indicated the facility oject in progress in the area and confirmed the kitchen occurred when the tarted. DD stated the facility ule for equipment used in med the above kitchen s were dirty. She indicated ded to be cleaned prior to	F 371	Audits are being completed weekly during construction then decreased to monthly and then quarterly if standards are consistently met. Results will be reporte to the quarterly QA meetin Responsible for on-going compliance: dining manage Dietitian, and Administrato Completion Date: May 14, 2014.	1 ed g.		
	she would expect the would expect rust be equipment or repaired Review of the cleanin facility revealed the fa schedule, week one th equipment and areas schedules listed vario clean the dish dollies, cleaned, clean the Co microwave. Review of facility polic Mop Rooms"revised of maintain cleanliness of prevent odor and main titled, "Cleaning all sin indicated to wash inside	t to remove the rust. g schedules provided by the cility utilized a rotating					

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

Event ID: KPNL11

Facility ID: 00013

If continuation sheet Page 6 of 7

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVE
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245489	B. WING			04/	10/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EMMANU	EL NURSING HOME				415 MADISON AVENUE ETROIT LAKES, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	be clean and sanitary illness and clean as n lacked direction on he a clean and sanitary n	Dvens", indicated the ovens to prevent food borne needed. The facility policies by to maintain the kitchen in manner during situations nor did the policies direct an	F 3	371			
ORM CMS-256	(02-99) Previous Versions Obs	olete Event ID: KPN		Fac	sility ID: 00013 If conti	inuation sh	eet Page 7 of

PRINTED: 04/24/2014

Addendum to MN department of Health Survey completed on 4/10/14 for Emmanuel Nursing Home

Tag 241 Dignity

We identified those residents at risk by observing each dining time in each dining room and AM, afternoon and evening activity times. We observed all residents for any dignity issues including but not limited to personal appearance and wearing a transfer belt.

Cheryl Krause, RN

**Director of Nursing** 

**Emmanuel Nursing Home** 

	MENT OF HEALTH				489022	FORM	04/10/2014 APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE			PLE CONSTRUCTION G 01 - 2004 BUILDING 2008 KITCHEN	(X3) DATE S COMPLE	
		245489		B. WING		04/0	9/2014
	ROVIDER OR SUPPLIER UEL NURSING HON	1E	1415 M	ADISON A	STATE, ZIP CODE VENUE , MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY <sub>.</sub> 01 1963 Main Build	ing					
	Minnesota Departm Marshal Division on this survey Emman Main Building was f requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing The Emmanuel Nur	at 42 CFR, Subpart ty from Fire, and the ire Protection Assoc 01, Life Safety Code	Fire le time of 1 1963 with the 2000 station (LSC),		12		
LABORATOR	basement and was construction. In 196 west wings were co basements and are 1978 an addition to the 1963 building wa a partial basement, II (000) construction 2-hour fire barrier. A constructed in 1992 the 1963 building, is was determined to b construction. In 199 was constructed to is one story without Type II (111) constru- building was constru- building, is 1-story w is a Type II (000) co a 2-hour fire rated b	determined to be Ty 6 additions to the ea nstructed, are 1-stor Type II (111) constru- the north of the north as constructed, is 1- was determined to b a, and is separated w chapel addition was and attached to the 5 1-story with a basen be of Type II (000) 7 a sleeping room ac the west of the 1978 a basement and whi action. In 2004 a sep acted west of the 196 <i>v</i> ith a partial basement nstruction and separa arrier. In 2008 a kitc	pe II (111) ist and y without uction. In h wing of story with be of Type rith a south of ment and ddition addition, ch is a arate 53 main nt, which rated with hen	NATURE	TITLE		(X6) DATE
LABORATOF	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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.

	MENT OF HEALTH					FORM	04/10/2014 APPROVED . 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM			PLE CONSTRUCTION G 01 - 2004 BUILDING 2008 KITCHEN	(X3) DATE SU COMPLE	
		245489		B. WING		04/0	9/2014
	PROVIDER OR SUPPLIER			DRESS, CITY, S			
					, MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	expansion was component of the 1963 if basement and is set assisted living build and was determined construction. The building is compautomatic fire sprint with NFPA 13 Stand Sprinkler Systems of fire alarm system the corridor smoke detection in all compactordance with NFPA 13 Stand Sprinkler System in accordance with NFPA 13 Stand System in accordance with NFPA 14 arm Code" 1999 automatic fire detection system in accordance system in accordance system in accordance fire Code and the 1 single station smoke rooms that annuncies stations in accordance fire Code 2007 edit The building is divid minute, 1 hour and Because the original meet the construction buildings and the 20 kitchen addition, meet the LSC, this facility buildings, one exist The facility has a capenda census of 115 at the set of the station of the set	structed to the south building, is 1-story, fu- parated form the new ing with a 2-hour fire d to be Type II (111) pletely protected with kler system in accord and for the Installation 1999 edition. The fac- lat includes 30-foot of ection, with additional mon areas installed if PA 72 "The National edition. Hazardous and tors that are on the file exters that are on the file exters that are on the file ates at the respective foce with the Minnesot 1997 and 2004 additi e detection in the sle ates at the respective foce with the Minnesot on symbol and its add on type allowed for e 004 building and its add on type allowed for e 004 building require was surveyed as a file and one new. apacity of 140 beds a a time of the survey. 42 CFR, Subpart 48	ull w barrier h an dance on of cility has a on center l in l Fire reas have ereas have eping e nurse's ta State ons have eping e nurse's ta State es by 30 rs. ditions xisting 2008 tirements two	K 000			

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

If continuation sheet Page 2 of 2

	MENT OF HEALTH			FSY	89027	FOR	1: 04/10/2014 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	PLE CONSTRUCTION	(X3) DATE S COMPL	
		245489		B. WING		04/0	09/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
EMMAN	UEL NURSING HON	IE		ADISON A			
			DETRO	IT LAKES,	MN 56501		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY						
	02 2004 Building ar	d 2008 Kitchen Add	ition	- (s			
	Minnesota Departm Marshal Division on this survey Emman Building and 2008 k compliance with the in Medicare/Medica 483.70(a), Life Safe	id at 42 CFR, Subpa ty from Fire, and the ire Protection Assoc 01, Life Safety Code	Fire time of 2 2004 found in articipation art 2 2000 station				12
	The Emmanuel Nur as a 1-story building basement and was construction. In 196 west wings were co- basements and are 1978 an addition to the 1963 building wa a partial basement, II (000) construction 2-hour fire barrier. A constructed in 1992 the 1963 building, is was determined to b construction. In 199 was constructed to to is one story without Type II (111) constru- building was constru- building, is 1-story w is a Type II (000) co	with a partial walko determined to be Ty 6 additions to the ea instructed, are 1-stor Type II (111) constru- the north of the north as constructed, is 1- was determined to b , and is separated w chapel addition was and attached to the 1-story with a basen of Type II (000) 7 a sleeping room ac the west of the 1978 a basement and whi action. In 2004 a sep acted west of the 196 ith a partial baseme	ut pe II (111) ist and y without uction. In h wing of story with pe of Type rith a south of ment and ddition addition, ch is a arate 53 main nt, which				
LABORATOR	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	IATURE	TITLE		(X6) DATE

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.

	MENT OF HEALTH			- 1/2		FORM	: 04/10/2014 MAPPROVED 0. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION G <b>02 - 1963 MAIN BUILDING</b>	(X3) DATE S COMPL	
		245489		B. WING		04/0	09/2014
	PROVIDER OR SUPPLIER	1E	1415 N	ADISON A	STATE, ZIP CODE VENUE , MN 56501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	a 2-hour fire rated to expansion was con- corner of the 1963 basement and is se- assisted living build and was determine construction. The building is com- automatic fire sprin with NFPA 13 Stand Sprinkler Systems of fire alarm system th corridor smoke deted detection in all com- accordance with NF Alarm Code" 1999 automatic fire detects system in accordan Fire Code and the of single station smok rooms that annunci stations in accordan Fire Code 2007 edi The building is divid minute, 1 hour and Because the origina- meet the constructio buildings and the 20 kitchen addition, me the LSC, this facility buildings, one exist The facility has a ca- census of 115 at the	barrier. In 2008 a kitcle structed to the south building, is 1-story, fur- eparated form the new ing with a 2-hour fire d to be Type II (111) pletely protected with kler system in accord dard for the Installation 1999 edition. The fact hat includes 30-foot of ection, with additional mon areas installed TPA 72 "The National edition. Hazardous a cors that are on the fi- ce with the Minnesof 1997 and 2004 additi e detection in the sle ates at the respective new with the Minnesof 1997 and 2004 additi e detection in the sle ates at the respective new with the Minnesof 1997 and 2004 additi e detection in the sle ates at the respective new with the Minnesof 1997 and 2004 additi e detection in the sle ates at the respective new with the Minnesof 1997 and 2004 additi e detection in the sle ates at the respective new with the Minnesof 1997 and 2004 additi e detection in the sle ates at the respective and on the sle ates at the respective on type allowed for e 004 building and its add on type allowed for e 004 building require was surveyed as a ing and one new. 42 CFR, Subpart 48	west ull w barrier h an dance on of ility has a on center l Fire reas have fire alarm ta State ons have eeping e nurse's ita State des by 30 rs. ditions xisting 2008 uirements two and had a	K 000			

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

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7531

April 24, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5489022

Dear Ms. Green:

The above facility was surveyed on April 7, 2014 through April 10, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Emmanuel Nursing Home April 24, 2014 Page 2

## 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1505 Pebble Lake Road Suite #300 Fergus Falls Minnesota. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140.

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

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

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

Sincerely,

## Monh Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5489s14lic

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED
		00013	B. WING		04/10/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
EMMANU	EL NURSING HOME		DISON AVENUE	501	
			T LAKES, MN 56	PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTEN	TION*****			
	NH LICENSING C	ORRECTION ORDER			
	144A.10, this correcti pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart Determination of whe corrected requires co requirements of the ru number and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessm	ther a violation has been			
	that may result from r orders provided that a the Department within notice of assessment INITIAL COMMENTS State-Initial Comment On April 07, 08, 09, 1	:		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to	ware.
Minecolo Do	the following licensing corrections are compl	orded the above provider and g orders were issued. When leted, please sign and date irst page in the line marked		Minnesota state statutes/rules for Nu Homes.	rsing

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

Executive Director KPNL11 met e en

(X6) DATE \_05 If continuation sheet 1 of 9

RECEIVED

MAY 1 2 2014

MN Dept of Health Fergus Falls

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Minnesot	a Department of Healt	1				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
		00013	B. WING		04/10/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
EMMANUI	EL NURSING HOME		ISON AVENUE LAKES, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
2 000	Representative's sign	ctor's or Provider/Supplier ature." Make a copy of records and return the s below: nt of Health pad suite 300	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag. The state statute/rule number and the corresponding text of the state statute 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 whare in violation of the state statute after statement, "This Rule is not met as evidenced by." Following the surveyor findings are the Suggested Method of Correction. PLEASE DISREGARD THE HEADING 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 F VIOLATIONS OF MINNESOTA STATUTES/RULES.	" /rule ich r the ors G OF S	
21015	h	ary conditi	21015			
	This MN Requiremen by:	t is not met as evidenced				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

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If continuation sheet 2 of 9

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00013	B. WING		04	/10/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
EMMANUE	EL NURSING HOME					
			T LAKES, MN 5650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLE DATE
21015	Continued From page	ə 2	21015			
	review, the facility fail was maintained in a c for food preparation, s facility. This deficient	n, interview and document led to ensure the kitchen clean and sanitary manner storage and service in the practice had the potential to who were served food from				
	Findings include:					
	of the facility was con	m. tour of the main kitchen ducted, with the dining during the tour. During the s observed:				
	large areas of orange	oven was observed to have brown substance on the aces of the oven, which t to the oven.				
	stacks of individual w plates and cereal bow of the kitchen. A layer	ue rolling carts which held white dinner plates, desert vls was observed in a corner of whitish dirt like material er the entire top and bottom on cart with dishes.				
	on a metal shelf, all c whitish dust and parti- had a build up of blac with a layer of whitish silver shelf was cover and dirt particles on it grill was a indoor blac had raised black color the grill there was a s	grill, and black colored grill overed with a thin layer of cles, and grates on the grill k material, also covered dust and particles. The red with a thin layer of dust c. On the right side of the flat ck colored grill. The grate r substance on it and under ilver shelf which was yer of dust and dirt particles.				
		on a shelf had a thin layer				

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	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00013	B. WING		04	1/10/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE		
-		1415 MAI	DISON AVENUE			
	EL NURSING HOME	DETROIT	LAKES, MN 5650	)1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
21015	Continued From page	3	21015			
	of whitish dust and di oven and the shelf. A a silver sink, with exp	rt particles covering both the cross from the Convi oven, osed white drainage piping, er of brownish substance on				
	had a light layer of wh surfaces. On the right table was a silver cold black microwave sittir	eam table and plate warmer hitish dust on it covering the t side of the serving steam ored countertop with a small ng on it, which also had a ering the surfaces of the				
	had a construction pro- outside of the kitchen increased dust in the construction project s had a cleaning sched the kitchen and confir equipment and disher equipment used, nee- use because of the co confirmed the equipm	kitchen occurred when the tarted. DD stated the facility ule for equipment used in med the above kitchen s were dirty. She indicated ded to be cleaned prior to				
	facility revealed the fa schedule, week one to equipment and areas schedules listed vario clean the dish dollies,	g schedules provided by the acility utilized a rotating hru four, for cleaning in the kitchen. The rotating us tasks which included steam table and shelf to be ombie oven, and clean the				

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If continuation sheet 4 of 9

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED
		00013	B. WING		04	4/10/2014
	Rovider or supplier El nursing home	1415 MA	ADDRESS, CITY, STATE DISON AVENUE T LAKES, MN 5650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Mop Rooms"revised of maintain cleanliness of prevent odor and mai titled, "Cleaning all sir indicated to wash insi- sink and to clean the Cleaning the Combi O be clean and sanitary illness and clean as n lacked direction on ho a clean and sanitary of such as construction a increase in the cleanin construction time. SUGGESTED METHO The Administrator and and revise the cleaning to assure that the kito sanitary manner. Sta necessary. The Certi monitor the cleanlines periodic basis to ensu- maintained in the ope department. The qua could design a monitor compliance.	cy titled, "Broom Closet and on 6/17/2009, indicated to of all areas of kitchen, to ntain sanitization. The policy hks", revised on 6/17/2009, de and outside areas of the pipes. The policy titled, Ovens", indicated the ovens to prevent food borne eeded. The facility policies ow to maintain the kitchen in manner during situations nor did the policies direct an ng schedule during OD OF CORRECTION: If the Dietician could review to g policies and procedures hen is maintained in a ff could be trained as fied Dietary Manager could is of the kitchen on a re sanitary conditions are ration of the dietary lity assurance committee	21015			
21805	MN St. Statute 144.66 Residents of HC Fac.	Bill of Rights	21805			
	Subd. 5. Courteous residents have the rig	treatment. Patients and ht to be treated with				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			e survey Pleted
		00013	B. WING		04	COMPLETED 04/10/2014 (X5) COMPLETE DATE
	Rovider or Supplier El Nursing Home	1415 MA	ADDRESS, CITY, STATE ADISON AVENUE T LAKES, MN 5650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLE
21805	courtesy and respect	e 5 for their individuality by ons providing service in a	21805			
	by: Based on observatior review, the facility fail dining experience for	ransfer/gait belt during				
	4/6/14, identified R70 included dementia, se schizophrenia. The M severe cognitive impa assistance from staff daily living (ADL). Re summary dated 4/8/1 diagnoses which inclu schizophrenia, demen compulsive disorder. was disoriented, utiliz transfers, and ambula use of the gait belt an care plan, revised 4/8	IDS identified R70 had airment, and required to complete all activities of view of the quarterly 4, revealed R70 had uded paranoid htia, and obsessive The summary identified R70 red a transfer belt for all ated with assistance and the d walker. Review of the k/14 directed extensive ff for ADL's, and directed				
	from 6:00 p.m. to 6:37 table in the small mer male residents were so four residents were so	the supper meal on 4/7/14, 1 p.m., R70 was seated at a nory unit dining area. Two seated at R70's table, and eated at another table in the a white cloth transfer belt,				

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If continuation sheet 6 of 9

#### Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00013 04/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE EMMANUEL NURSING HOME DETROIT LAKES, MN 56501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21805 Continued From page 6 21805 with red and blue stripes, fastened around R70's waist. The white striped transfer belt remained fastened around R70's waist during the entire meal. At 6:31 p.m. registered nurse (RN)-B assisted R70 to ambulate to his room and transfer into the recliner. After RN-B assisted R70 to sit in his recliner, she removed the white striped transfer belt from his wait. During observation on 4/9/14, from 7:32 a.m. to 8:37 a.m., R70 was seated at a table in the memory unit small dining area with other residents, eating the breakfast meal. R70 had a white striped transfer belt fastened around his waist. At 7:39 a.m., R70 reached up and repeatedly pulled on the buckle and strap of the transfer belt. At 8:00 a.m., R70 resumed eating, the transfer belt remained fastened around his waist. The white striped transfer belt remained fastened around R70's waist during the entire observation. At 8:37 a.m. nursing assistant (NA)-A assisted R70 back to his room to go to the bathroom. At 8:49 a.m. R70 was sitting in his recliner in his room and the transfer belt was observed hanging on his walker in front of him. During observation on 4/9/14, from 12:00 p.m. to 12:31 p.m., R70 was seated at a table with other residents in the memory unit small dining room, eating lunch. Again, R70 had the white striped transfer belt fastened to his waist, for the entire observation period. At 12:31 p.m., a facility staff member assisted R70 back to his room, to lie down in bed. The transfer belt was removed at that time. On 4/9/14 at 12:34 p.m. social services (SS)-A indicated she routinely assisted with meals and confirmed R70 routinely ate his meals with a transfer belt fastened to his waist. She confirmed Minnesota Department of Health

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If continuation sheet 7 of 9

### Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00013 B. WING 04/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1415 MADISON AVENUE EMMANUEL NURSING HOME DETROIT LAKES, MN 56501 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21805 Continued From page 7 21805 staff did not remove the transfer belt during meals for R70. On 4/9/14 at 12:35 p.m. licensed practical nurse (LPN)-A confirmed R70 routinely wore the transfer/gait belt around his waist during meals and confirmed staff did not routinely remove the transfer/gait belt during meal time. On 4/9/14 at 12:37 p.m. R70 he indicated that he did not know why he wore the white striped belt during meal times, and stated "I don't like it on, they just leave it on" and indicated he would like it off during meals. On 4/9/14 at 12:40 p.m. registered nurse (RN)-A confirmed R70 routinely wore a transfer belt fastened to his waist during meals. RN-A stated "he shouldn't have it on during meals because it is a dignity issue." On 4/10/14 at 4:20 p.m. the director of nursing (DON) confirmed R70 routinely wore a gait belt during all meals and staff do not remove it. She indicated she was not aware R70 did not like to wear the belt during meals. She confirmed R70's current care plan and confirmed the current facility policy. The DON stated residents should not wear a gait belt during meals unless they request to wear it. Review of the facility policy titled Dignity, revised 11/2013, indicated staff are to provide care for all residents in a manner and in a environment that promotes dignity and respect of each individual resident and their unique needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could Minnesota Department of Health

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AND FLAN OF CORRECTION     DEMINICATION NOMBER:     A BUILDING:     Contraction       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     04/10/201       Image: Contract of the stand digits of the	ND PLAN OF CORRECTION
VAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       MAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       MMANUEL NURSING HOME       DETROIT LAKES, MN 56501       (CA) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICE/CON MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D       PROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICE/MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       21805       Continued From page 8       develop a policy and procedure related to monitoring the appropriate use of gait transfer belts and dignity during the dining process. The Director of Nursing or designee could train staff on the new policy and procedure. The Director of Nursing or designee could monitor periodically to ensure all residents are provided a dignified dining experience. The quality assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen	
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