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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KPNL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00013

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/28/2014** (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 **112** (L18)

13.Total Certified Beds **112** (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
	112			
(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 :
Tammy Williams, HFE NEII 06/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/31/2014 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/01/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/30/2014
(L33)

DETERMINATION APPROVAL

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 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

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	05/14/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	05/14/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/GA	Date: 06/12/2014	Signature of Surveyor: 32603	Date: 05/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/10/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	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

AH Form Approved
6/12/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00013	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

This report is completed by a 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	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	**05/28/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**05/28/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** MM/GA	**Date:** 06/12/2014	**Signature of Surveyor:** 32603	**Date:** 05/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/10/2014		**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: KPNL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00013

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

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

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

4. TYPE OF ACTION: **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 **04/10/2014** (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 **112** (L18)

13.Total Certified Beds **112** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___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

X 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
	112			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 05/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/27/2014 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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 teh facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
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

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

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 related to this letter.

Sincerely,

Mark 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

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
	245489	A. BUILDING _____ B. WING _____	04/10/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(X5) COMPLETION DATE
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		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 1 of 1 resident (R70) observed wearing a transfer/gait belt during meals in the memory unit. Findings include: The quarterly Minimum Data Set (MDS) dated 4/6/14, identified R70 had diagnoses which included dementia, seizure disorder, and schizophrenia. The MDS identified R70 had severe cognitive impairment, and required assistance from staff to complete all activities of daily living (ADL). Review of the quarterly	F 241	F-241 The one resident observed was wearing a transfer belt while dining on the memory care unit has been observed to put the belt back on during the meal. The belt is now always removed by staff and it is placed behind him on his chair. The care plan has been updated to reflect his stated desire to not have the belt left on during meals. Care giver education was completed by April 16, 2014. Random audits throughout the nursing home have been completed weekly for four weeks then quarterly two times. Compliance is reported at the quarterly QA meeting. Audits have not identified any residents having a transfer belt on during meals or activities. Responsible for ongoing compliance: DON and RN managers. Completion Date: May 14, 2014.	

OK w/ addendum
5/16/14

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

Janet Green — Executive Director — 05/09/14

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
	245489	A. BUILDING _____ B. WING _____	04/10/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1	F 241		

summary dated 4/8/14, revealed R70 had diagnoses which included paranoid schizophrenia, dementia, and obsessive compulsive disorder. The summary identified R70 was disoriented, utilized a transfer belt for all transfers, and ambulated with assistance and the use of the gait belt and walker. Review of the care plan, revised 4/8/14 directed extensive assistance of one staff for ADL's, and directed staff to utilize a gait belt with transfers and ambulation for R70.

During observation of the supper meal on 4/7/14, from 6:00 p.m. to 6:31 p.m., R70 was seated at a table in the small memory unit dining area. Two male residents were seated at R70's table, and four residents were seated at another table in the same area. R70 had a white cloth transfer belt, 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

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	245489	A. BUILDING _____ B. WING _____	04/10/2014

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 241	Continued From page 2 (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 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."	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	04/10/2014

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F 241	Continued From page 3 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.	F 241		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for food preparation, storage and service in the facility. This deficient practice had the potential to affect all 94 residents who were served food from	F 371	F-371 The outside of the oven has been sanded and painted with a high temperature appliance paint to eliminate flaking and to resolve the rust spots. Construction has resulted in increased dust at times in the kitchen requiring additional cleaning. Periodically the kitchen has been closed for part of the day to prevent food and supplies from being exposed to the dust and to allow for additional cleaning. Additional barriers to the kitchen entry have been added and the ceiling has been permanently closed.	

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F 371	Continued From page 4 the kitchen. Findings include: On 4/9/14 at 12:14 p.m. tour of the main kitchen of the facility was conducted, with the dining director (DD) present during the tour. During the tour the following was observed: - A Southbend brand oven was observed to have large areas of orange brown substance on the outside surfaces of the oven, which flaked off with contact to the oven. - Three uncovered blue rolling carts which held stacks of individual white dinner plates, desert plates and cereal bowls was observed in a corner of the kitchen. A layer of whitish dirt like material was observed to cover the entire top and bottom shelf surfaces of each cart with dishes. - A silver colored flat grill, and on the right side of the flat grill, was a indoor black colored grate. The grates on the grill had a large amount of build up of black material. In addition, the silver shelf underneath grill was covered with a thin layer of dust and dirt particles. - A Convi brand oven on a shelf had a thin layer of whitish dust and dirt particles covering both the oven and the shelf. Across from the Convi oven, a silver sink, with exposed white drainage piping, 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	F 371	Policies have been updated to address the need for additional cleaning due to construction. Residents have not been served using any dishes, carts or equipment that have dust on them. Additional cleaning has occurred. Paper dishes have been used throughout construction to prevent breaking and cracking during transport around and through the construction area. The flat grill is not being used. The brownish substance on the sink pipe has been cleaned. Staff education to ensure proper cleaning during construction was completed by 4/18/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 5 black microwave sitting on it, which also had a thin layer of dust covering the surfaces of the microwave. On 4/9/14, at 12:30 p.m. DD indicated the facility had a construction project in progress in the area outside of the kitchen and confirmed the increased dust in the kitchen occurred when the construction project started. DD stated the facility had a cleaning schedule for equipment used in the kitchen and confirmed the above kitchen equipment and dishes were dirty. She indicated equipment used, needed to be cleaned prior to use because of the construction dust. DD confirmed the equipment in the kitchen was available for use by staff to prepare or serve resident meals. On 4/10/14, at 3:41 p.m. the administrator stated she would expect the kitchen to be clean and would expect rust be removed from kitchen equipment or repaired to remove the rust. Review of the cleaning schedules provided by the facility revealed the facility utilized a rotating schedule, week one thru four, for cleaning equipment and areas in the kitchen. The rotating schedules listed various tasks which included clean the dish dollies, steam table and shelf to be cleaned, clean the Combie oven, and clean the microwave. Review of facility policy titled, "Broom Closet and Mop Rooms"revised on 6/17/2009, indicated to maintain cleanliness of all areas of kitchen, to prevent odor and maintain sanitization. The policy titled, "Cleaning all sinks", revised on 6/17/2009, indicated to wash inside and outside areas of the sink and to clean the pipes. The policy titled,	F 371	Audits are being completed weekly during construction then decreased to monthly and then quarterly if standards are consistently met. Results will be reported to the quarterly QA meeting. Responsible for on-going compliance: dining manager, Dietitian, and Administrator. Completion Date: May 14, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	04/10/2014

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F 371	Continued From page 6 Cleaning the Combi Ovens", indicated the ovens be clean and sanitary to prevent food borne illness and clean as needed. The facility policies lacked direction on how to maintain the kitchen in a clean and sanitary manner during situations such as construction nor did the policies direct an increase in the cleaning schedule during construction time.	F 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**04/09/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY 01 1963 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on April 09, 2014. At the time of this survey Emmanuel Nursing Home 01 1963 Main Building was found in 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. The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 additions to the east and west wings were constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111) construction. In 2004 a separate building was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**04/09/2014**

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

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K 000	Continued From page 1 expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated form the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code and the 1997 and 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations in accordance with the Minnesota State Fire Code 2007 edition. The building is divided into 9 smoke zones by 30 minute, 1 hour and 90 minute fire barriers. Because the original building and its additions meet the construction type allowed for existing buildings and the 2004 building and the 2008 kitchen addition, meet new building requirements the LSC, this facility was surveyed as a two buildings, one existing and one new. The facility has a capacity of 140 beds and had a census of 115 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**04/09/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY 02 2004 Building and 2008 Kitchen Addition A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on April 09, 2014. At the time of this survey Emmanuel Nursing Home 02 2004 Building and 2008 Kitchen Addition was found in 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. The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 additions to the east and west wings were constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111) construction. In 2004 a separate building was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**04/09/2014**

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

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K 000	Continued From page 1 a 2-hour fire rated barrier. In 2008 a kitchen expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated form the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code and the 1997 and 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations in accordance with the Minnesota State Fire Code 2007 edition. The building is divided into 9 smoke zones by 30 minute, 1 hour and 90 minute fire barriers. Because the original building and its additions meet the construction type allowed for existing buildings and the 2004 building and the 2008 kitchen addition, meet new building requirements the LSC, this facility was surveyed as a two buildings, one existing and one new. The facility has a capacity of 140 beds and had a census of 115 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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.

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,

Mark 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00013	A. BUILDING: _____ B. WING _____	04/10/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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: State-Initial Comments On April 07, 08, 09, 10, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked	2 000	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.	

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	00013	A. BUILDING: _____ B. WING _____	04/10/2014

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2 000	Continued From page 1 with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 1505 Pebble Lake Road suite 300 Fergus Falls, MN 56537	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/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 evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by:	21015		

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21015	Continued From page 2 Based on observation, interview and document review, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for food preparation, storage and service in the facility. This deficient practice had the potential to affect all 94 residents who were served food from the kitchen. Findings include: On 4/9/14 at 12:14 p.m. tour of the main kitchen of the facility was conducted, with the dining director (DD) present during the tour. During the tour the following was observed: - A Southbend brand oven was observed to have large areas of orange brown substance on the outside and front surfaces of the oven, which flaked off with contact to the oven. - Three uncovered blue rolling carts which held stacks of individual white dinner plates, desert plates and cereal bowls was observed in a corner of the kitchen. A layer of whitish dirt like material was observed to cover the entire top and bottom shelf surfaces of each cart with dishes. - A silver colored flat grill, and black colored grill on a metal shelf, all covered with a thin layer of whitish dust and particles, and grates on the grill had a build up of black material, also covered with a layer of whitish dust and particles. The silver shelf was covered with a thin layer of dust and dirt particles on it. On the right side of the flat grill was a indoor black colored grill. The grate had raised black color substance on it and under the grill there was a silver shelf which was covered with a thin layer of dust and dirt particles. - A Convi brand oven on a shelf had a thin layer	21015		

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21015	Continued From page 3 of whitish dust and dirt particles covering both the oven and the shelf. Across from the Convi oven, a silver sink, with exposed white drainage piping, 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 black microwave sitting on it, which also had a thin layer of dust covering the surfaces of the shelf and microwave. On 4/9/14, at 12:30 p.m. DD indicated the facility had a construction project in progress in the area outside of the kitchen and confirmed the increased dust in the kitchen occurred when the construction project started. DD stated the facility had a cleaning schedule for equipment used in the kitchen and confirmed the above kitchen equipment and dishes were dirty. She indicated equipment used, needed to be cleaned prior to use because of the construction dust. DD confirmed the equipment in the kitchen was available for use by staff to prepare or serve resident meals. On 4/10/14, at 3:41 p.m. the administrator stated she would expect the kitchen to be clean and would expect rust be removed from kitchen equipment or repaired to remove the rust. Review of the cleaning schedules provided by the facility revealed the facility utilized a rotating schedule, week one thru four, for cleaning equipment and areas in the kitchen. The rotating schedules listed various tasks which included clean the dish dollies, steam table and shelf to be cleaned, clean the Combie oven, and clean the	21015		

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21015	Continued From page 4 microwave. Review of facility policy titled, "Broom Closet and Mop Rooms"revised on 6/17/2009, indicated to maintain cleanliness of all areas of kitchen, to prevent odor and maintain sanitization. The policy titled, "Cleaning all sinks", revised on 6/17/2009, indicated to wash inside and outside areas of the sink and to clean the pipes. The policy titled, Cleaning the Combi Ovens", indicated the ovens be clean and sanitary to prevent food borne illness and clean as needed. The facility policies lacked direction on how to maintain the kitchen in a clean and sanitary manner during situations such as construction nor did the policies direct an increase in the cleaning schedule during construction time. SUGGESTED METHOD OF CORRECTION: The Administrator and the Dietician could review and revise the cleaning policies and procedures to assure that the kitchen is maintained in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the cleanliness of the kitchen on a periodic basis to ensure sanitary conditions are maintained in the operation of the dietary department. The quality assurance committee could design a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		

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21805	Continued From page 5 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 1 of 1 resident (R70) observed wearing a transfer/gait belt during meals in the memory unit. Findings include: The quarterly Minimum Data Set (MDS) dated 4/6/14, identified R70 had diagnoses which included dementia, seizure disorder, and schizophrenia. The MDS identified R70 had severe cognitive impairment, and required assistance from staff to complete all activities of daily living (ADL). Review of the quarterly summary dated 4/8/14, revealed R70 had diagnoses which included paranoid schizophrenia, dementia, and obsessive compulsive disorder. The summary identified R70 was disoriented, utilized a transfer belt for all transfers, and ambulated with assistance and the use of the gait belt and walker. Review of the care plan, revised 4/8/14 directed extensive assistance of one staff for ADL's, and directed staff to utilize a gait belt with transfers and ambulation for R70. During observation of the supper meal on 4/7/14, from 6:00 p.m. to 6:31 p.m., R70 was seated at a table in the small memory unit dining area. Two male residents were seated at R70's table, and four residents were seated at another table in the same area. R70 had a white cloth transfer belt,	21805		

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21805	Continued From page 6 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	21805		

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21805	Continued From page 7 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	21805		

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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 (14) days.	21805		