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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LBDC

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/08/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 07/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/29/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245361
July 21, 2015

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

Dear Mr. Gamst:

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

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

Effective June 23, 2015 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 21, 2015

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

RE: Project Number S5361024

Dear Mr. Gamst:

On May 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 14, 2015. 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 July 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 25, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 14, 2015, effective June 23, 2015 and therefore remedies outlined in our letter to you dated May 29, 2015, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245361	A. Building B. Wing	7/8/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 06/23/2015	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/23/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 06/23/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	07/21/2015	10562	07/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
5/14/2015	YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245361	01 - MAIN BUILDING 01	6/25/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	06/23/2015	ID Prefix Reg. # NFPA 101 LSC K0144	06/15/2015	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	Date:	Signature of Surveyor:	Date:
	PS/KJ	07/21/2015	34764	06/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/12/2015

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: LBDC

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

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

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(L3) **EMMANUEL HOME**
(L4) **600 SOUTH DAVIS AVENUE**
(L5) **LITCHFIELD, MN** (L6) **55355**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/14/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mardelle Trettel, HFE NE II 06/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 06/29/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1680
May 29, 2015

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

RE: Project Number S5361024

Dear Mr. Gamst:

On May 14, 2015, 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 June 23, 2015, 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 June 23, 2015 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 August 14, 2015 (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 November 14, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Received 6/16/15 via email

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	05/14/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal grooming for 1 of 1 residents (R112) who had excessive facial hair on chin and neck. Findings include: R112's quarterly Minimum Data Set (MDS) dated 3/4/15, indicated the resident had moderate cognitive impairment, required supervision and set up help with her personal hygiene needs. The MDS further indicated that the resident had impaired vision and wore corrective lenses. Review of R112's plan of care updated 12/3/14, indicated R112 required assistance with personal	F 311	**F 311 D Treatment/services to improve/maintain ADLs.** **Plan of correction for residents cited with this survey:** 1. Resident R112 was provided a shaver on 5/12/15. Staff went back to resident on 5/14/15 and offered resident assistance in shaving the chin/neck hairs that were missed. 2. Added to care plan to assist resident, if chin/neck hairs are visible and resident desires, with shaving. **Plan to address and prevent this deficiency with other residents:** 1. If resident does not have a shaver available, the facility will provide shaver to them if needed. 2. Will audit all residents residing in the building for unwanted facial hair and offer them assistance with shaving if needed. 3. Will educate nursing staff members on the nursing care standards policy and the availability of shavers.	6/17/15 BA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blaine Gaun — TITLE: Executive Director — (X6) DATE: 6/15/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	05/14/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 1 hygiene as needed and identified R112 had impaired visual function related to diabetic retinopathy and only able to see large print. During observations and interview on 5/12/15 at 10:00 a.m., R112 was observed to have numerous long facial hairs around her chin and slightly down her neck. The hairs were approximately 1/2" long. Interview with the resident at this time stated she was not aware of her long facial hairs and that the staff have not assisted with or offered her shaving. She stated she did not have a shaver and if she was able to see the long hairs on her chin and neck area she would wanted them to be removed. During and observation and interview on 05/14/2015 at 9:53 a.m. R112 was observed to have 5-6 long whiskers on under side of chin and neck. She had been shaved the previous day but several long black whiskers remained. R112 stated she had shaved her own chin and neck the previous day but was not aware that she had missed several spots. During an interview on 5/12/15 at 10:30 a.m., registered nurse (RN)-B confirmed R112 had numerous long facial hairs on her chin and neck. (RN)-B stated R112 could not financially afford a shaver to trim her facial hairs since admission on 11/26/14 and that the facility did not have one for her to use. During interview on 5/12/15, at 11:30 a.m., the administrator confirmed the residents long facial hairs and the facility should have supplied the resident with a razor. During interview on 5/13/15 at 7:50 a.m., (LPN)-A	F 311	**Measures put into place to prevent in the future:** 1. Education will be provided to all nursing members on the nursing care standards policy and the availability of razors by June 23, 2015. **Plans to Monitor Performance:** 1. Will audit a random sample of 20% of residents for unwanted facial hair weekly x4 weeks, monthly x3 months, then quarterly. 2. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. Laurie Terning MSN,RN DON will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by June 23, 2015.	

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F 311	Continued From page 2 and (NA)-C both stated the resident always had long facial hair on her chin since admission. They both also stated that the resident did not have a razor and was unable to shave herself. During an interview on 05/14/2015 10:18 a.m. (NA)- D stated, R112 was " pretty independent" that staff assist with tub and personal cares, and assist with set up. (NA)-D stated she has not ever done anything with R112's chin whiskers and normally staff would take care of them. (NA)-D further stated cares needed should be on the residents care card on the back of her bathroom door. During an interview 05/14/2015 10:21 a.m., (RN)-A stated, related to facial hair on female residents, the facility promotes " taking care of it" as part of grooming process. (RN)-A further stated that needs related to grooming and personal cares would not be outlined on care sheets, but should identify individual preferences, and these cards were located on the back of bathroom door for nursing assistants to access. (RN)-A further stated that the "care sheet" refers to a copy of the initial plan of care. A facility policy titled Ecumen Nursing Care Standards dated Feb 2012 directed staff to ensure that every resident receives care to reach their highest practicable level of function, the standard listed below shall be followed. Procedure: assist with supervision of shaving residents as necessary to keep them clean and well groomed.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 3 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassessment urinary incontinence for 1 of 3 residents (R79) who was frequently incontinent of urine. Findings include: R79's admission Minimum Data Set (MDS) dated 1/14/15, indicated she was moderately cognitively impaired. The MDS further indicated she required extensive assist of two staff for transfers to the toilet and was frequently incontinent of bladder. R79's significant change MDS dated 4/16/15, identified R79 needed limited assistance of one staff for transfers which was a change from the 1/14/15 MDS, but continued to be frequently incontinent of bladder. A Care Area Assessment Summary dated 1/14/15 and 4/27/15, both identified R79 was prompted by staff to void every two hours if she has not called due to a history of R79 falling trying to toilet herself.	F 315	**F315 No catheter, prevent UTI, restore bladder.** **Plan of correction for residents cited with this survey:** 1. Bladder reassessment completed for resident R79. 2. Care plan updated with any changes related to bladder assessment. **Plan to address and prevent this deficiency with other residents:** 1. Will audit all bladder assessments for residents who are frequently incontinent and reassess those found to have changes. 2. Will educate the nurse managers on bladder assessments and care planning related to toileting. **Measures put into place to prevent in the future:** 1. Education will be provided to the nurse managers on bladder assessments and care planning related to toileting by June 23, 2015.	

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F 315	Continued From page 4 A 4 Day Elimination Record dated 1/8/15 to 1/11/15, identified that on 1/8/15 R79 had a medium incontinent void at 12:00 a.m. and a large incontinent void at 5:00 a.m.; 1/9/15 there was no documentation of R79's voiding pattern until 4:00 p.m.; 1/10/15, R79 had a large incontinent void at 12:00 a.m. and on 1/11/15 she had a large incontinent void at 4:00 a.m. Thus identifying a pattern of five medium to large voids between 12:00 a.m. and 4:00 a.m. in a four day period. The Bowel and Bladder Assessment dated 1/14/15, indicated staff were to offer toileting every two hours and that R79 had no desire to implement an aggressive toileting plan at night because of fatigue. The assessment further indicated they would address the residents toileting program after R79 felt better. Although R79's 4 Day Elimination Record dated 1/8/15 to 1/11/15, identified a voiding pattern between 12:00 and 4:00 a.m. there was no indication the facility had identified this, or had reassessed her urinary incontinence to date even though the 1/14/15 assessment identified they would readdress R79's toileting program after she felt better. R79's care plan last updated on 2/4/15 identified a problem with urge and functional incontinence with a goal of maintaining 90% urinary continence during waking hours. Staff were directed to assist the resident to toilet every 2 hours and provide peri-care after incontinence. During an interview on 5/13/15 at 8:27 a.m., nursing assistant (NA)-A stated that R79 required assistance of one staff for transfers, toileting and	F 315	**Plans to Monitor Performance:** 1. Will audit a random sample of 20% of residents who are frequently incontinent for bladder assessments and toileting plans x4 weeks, monthly x3 months and then quarterly. 2. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. Laurie Terning MSN,RN DON will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by June 23, 2015.	

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F 315	Continued From page 5 that R79 was usually wet upon rising. During an interview on 5/14/15, at 10:08 a.m., NA-B stated R79 was toileted every two hours but will sometimes ring before that. She stated R79 usually knows when she needs to go during the day but was unaware of this urgency at night. She stated R79 has no specific toileting plan but needed assistance for transfers. During an interview on 5/14/15, at 2:15 p.m. the director of nursing (DON) stated all resident interventions should be re-evaluated for effectiveness. Although R79 Bowel and Bladder Assessment dated 1/14/15, indicated staff were to offer toileting every two hours and R79 had no desire to implement an aggressive toileting plan at night due to fatigue. The assessment identified this would be reevaluated after R79 felt better, but the facility never reassessed R79's bladder function, to help decrease R79 episodes of early morning incontinence. A facility policy, dated May 2011, labeled Ecumen Assessment IDT directed staff to, complete a comprehensive assessment and to review and update assessments as needed, e.g. hospitalization, acute illness, change in status and at least quarterly.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	Continued From page 6 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate interventions to reduce the risk of falls for 1 of 4 residents (R79) identified as high risk for falls with frequent falls related to bladder incontinence. Findings include: During observation on 5/13/15, at 9:03 a.m., R79 was sitting in her room eating breakfast and had a dark purple bruise from her forehead approximately two inches in size with extensive bruising over her face. R79 stated her facial bruising was the result of a fall while attempting to take herself to the bathroom. She stated she tripped on her wheel chair and hit her head. During an interview on 5/13/15 at 8:27 a.m., nursing assistant (NA)-A stated that R79 required assistance of one staff for transfers and toileting. She stated that R79 was usually wet upon rising and staff are directed to toilet her every two hours. During an interview on 5/14/15, at 10:08 a.m., (NA-) B stated R79 was toileted every two hours but will sometimes ring before that. She stated R79 usually knows when she needs to go during the day but is unaware at night. She stated R79 has no specific toileting plan but needs assistance for transfers.	F 323	**F323 Free of accident hazards/supervision/devices** **Plan of correction for residents cited with this survey:** 1. Bladder reassessment completed for resident R79. 2. Care plan updated with any changes related to bladder assessment. **Plan to address and prevent this deficiency with other residents:** 1. Will review incidents from the last quarter and complete a bladder assessment for all residents who have had a fall r/t a toileting need and are frequently incontinent. 2. Will educate the nurse managers on bladder assessments, incidents and care planning related to toileting. **Measures put into place to prevent in the future:** 1. Education will be provided to the nurse managers on bladder assessments, incident reports and care planning related to toileting by June 23, 2015.	

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F 323	Continued From page 7 R79's significant change MDS dated 4/16/15, identified R79 required limited assistance of one staff for transfers and remained frequently incontinent of bladder. A Care Area Assessment Summary dated 4/27/15, identified R79 was prompted by staff to void every two hours if she has not called and has fallen trying to toilet herself. R79's Initial Care Plan initiated on 1/15/15 and updated on 2/4/15, indicated R79 had potential for injury (falls) related to history of falls, poor safety judgement and decreased insight into physical status. The goal was to have no falls related injury and staff were directed to remind resident to use call light, assist of 1 staff for all transfers and ambulation, reminders sign placed on wall to wait for help. On 4/29/15 anti-rollbacks and another resident reminder sign were added to the care plan. R79's fall risk assessments dated 1/14/15, 1/21/15, 2/4/15, 2/23/15, and 3/2/15 all indicated R79 was at a high risk for falls due to a history of falls, weakness, use of ambulatory aide and overestimation of her own limits. The fall assessments identified R79 was forgetful but followed commands and sometimes was aware of her toileting needs. A review of the Resident Incident Report dated 1/9/15, indicated R79 was found lying on the floor in her room on the way to the bathroom at 5:30 p.m. The RN assessment and plan of action indicated R79 was counseled to use call light for help with transfers and toileting. A sign would be hung in R79's room to remind her to call for help. A Resident Incident report dated 2/24/15,	F 323	**Plans to Monitor Performance:** 1. IDT will review 100% of incident reports and focus on appropriate interventions when fall is related to toileting. 2. Will follow our QAPI recommendations for necessary changes as relates to our incident reporting and interventions. Laurie Terning MSN, RN DON will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by June 23, 2015.	

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F 323	Continued From page 8 indicated R79 attempted to take herself to the bathroom and fell to the floor at 11:00 p.m. The RN assessment and plan of action indicated anti-rollbacks were place on R79's wheel chair and would be offered toileting at 10:00 p.m. The toileting intervention was not added to R79 care plan. A Resident Incident Report dated 4/29/15, at 10:15 p.m., indicated R79 was trying to get up from her wheel chair in the doorway between her bathroom and room and fell forward resulting in a bruise on her forehead, extensive facial bruising and a skin tear on her right forearm. The registered nurse (RN) assessment and plan of action indicated that staff would put a sign on her closet door reminding her to call for help. Although R79 had three falls going to or from the bathroom, the facility had not reassessed R79 bladder function to determine an appropriate toileting program to help decrease R79's risk of falls. The interventions identified were to place signs up in R79's room reminding her to call for help, even though R79 was identified by the facility has being moderately cognitively impaired. During an interview on 5/14/15 (RN)-A stated that when falls occur, they are discussed at IDT (interdisciplinary team) meetings. Interventions are placed as appropriate and care plan should be altered with new interventions. During an interview on 5/14/15, at 2:15 p.m. the director of nursing (DON) stated that falls are reviewed at IDT meetings, interventions put in place should be different for each fall and should prevent further falls. The DON further stated the care plan should be updated with each new	F 323		

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F 323	Continued From page 9 intervention and that all interventions should be re-evaluated for effectiveness. A facility policy, dated May 2011, labeled Ecumen Assessment IDT directed staff to, "...complete a comprehensive assessment ... and to review and update assessments as needed, e.g. hospitalization, acute illness, change in status and at least quarterly."	F 323		

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

F5361024

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/12/2015

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 12, 2015. At the time of this survey, Emmanuel Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok 6-16-15 RECEIVED JUN 16 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-23-15
EXIT: 5-14-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blaine Bowman
TITLE: Executive Director
(X6) DATE: 6/15/15

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Emmanuel Home is a one-story building with partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 86 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062	**K062 Life Safety Code Standard** **Description of what has been, or will be done, to correct the deficiency.** 1. Resident in room 413, their room was looked at and items moved so that they were at least 18 inches from the fire sprinkler. 2. Education provided to all staff members to make sure that items are at least 18 inches from fire sprinkler head. 3. Will audit 100% of resident rooms to make sure that items are at least 18 inches from sprinkler head.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system in accordance with the provisions at NFPA 101 (2000) Chapter 19 and NFPA 13 (1999). In a fire emergency, this deficient practice could adversely affect the resident in this room and visitors and staff. FINDINGS INCLUDE: On 05/12/2015 at 1: 00 PM, while surveying room 413 the sprinkler head was covered by bedding and other items in the closet being stored within 18-inches from a fire sprinkler. This arrangement was not in conformance with NFPA 13 (99), Chapter 5, Sections 5-5.5.2.1 and 5-5.6. Continuous or noncontinuous obstructions less than or equal to 18-inches below a sprinkler deflector can prevent the spray pattern from fully developing. This finding was verified with the Maintenance Director (MJ).	K 062	4. Education will be provided at monthly fire drills. 5. Will audit a random sample of 20% of resident rooms weekly x4 weeks, monthly x3 months and then quarterly, to make sure items are at least 18 inches from sprinkler head. 6. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. **The actual, or proposed, completion date.** 1. Tuesday, June 23, 2015 **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** 1. Environmental Director, will be responsible for correction and monitoring to prevent reoccurrence.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/12/2015

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EMMANUEL HOME	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. In a fire or other emergency, this deficient practice could adversely affect 90 of 90 residents, staff and visitors. FINDINGS INCLUDE: During a review of the emergency back up generator weekly/monthly inspection and testing logs for the dates 12/31/2014- 01/27/2015 were not completed due to the following: 1) Deputy Fire Marshal received a call from the Executive Director that they did not have a functioning back up generator on 1/12/15. Discussed the back up emergency evacuation plan and the need to have a rental brought to the facility. He assured me one would be ordered. 2) Deputy Fire Marshal Marshal received a call from the Executive Director on 01/28/2015 stating that the rental had arrived. 3) Permanent back up generator arrived as of 05/05/2015. This finding was confirmed with the Maintenance Director (MJ).	K 144	**K144 Life Safety Code Standard** **Description of what has been, or will be, done to correct the deficiency.** 6/15/15 1. New generator installed and monthly tests being performed, as required. **The actual, or proposed, completion date.** 1. Permanent generator was installed April 18, 2015. **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** 1. Environmental Director, will be responsible for correction and prevention of future occurrence.	