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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M0KQ

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 **07/14/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **102** (L18)

13.Total Certified Beds **102** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 07/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/17/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/18/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245489 July 19, 2017

Ms. Katie Lundmark, Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

Dear Ms. Lundmark:

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 30, 2017 the above facility is certified for or recommended for:

102 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 102 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 19, 2017

Ms. Katie Lundmark, Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: Project Number S5489026

Dear Ms. Lundmark:

On June 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 24, 2017. 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 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2017 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 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 24, 2017, effective June 30, 2017 and therefore remedies outlined in our letter to you dated June 1, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M0KQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00013

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2017** (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) :

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13.Total Certified Beds **102** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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 NE II 06/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/18/2017 (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 :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2017

Ms. Katie Lundmark, Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, MN 56501

RE: Project Number S5610025

Dear Ms. Lundmark:

On May 24, 2017, 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 electronically delivered CMS-2567 whereby corrections are required.

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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
gail.anderson@state.mn.us
Telephone: (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 July 3, 2017, 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 July 3, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 24, 2017 (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 24, 2017 (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 an ePoC 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	05/24/2017

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R19) reviewed for choices was provided bathing preferences according to previous life routines.	F 242	F242 SELF-DETERMINATION-RIGHT TO MAKE CHOICES	6/21/17

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

Electronically Signed | 06/06/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	05/24/2017

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 242	Continued From page 1 Findings include: When interviewed on 5/24/17, at 11:39 a.m. R19 stated she was not given a choice on how many baths she preferred to receive each week. R19 stated when she was admitted to the facility she was told she could only have one bath each week and was not given a choice of bathing frequency, bathing time or which day of the week worked best for her. R19 stated the facility just set it up, and did not give her any options or tell her that she could request to change the bathing schedule in the future. R19 reported she took a bath every other day at home and would like to have more baths now. Further, R19 stated she had hemorrhoids and believed it would increase her comfort level to be able to soak in the bath tub more frequently. R19 reported she did have a shower in her bathroom and could complete that task mostly on her own, but preferred a bath over a shower. R19's Diagnosis Report dated 5/1/17, indicated R19 had diagnoses which included chronic kidney disease with heart failure, end stage renal disease, pneumonia, chronic pain, major depressive disorder and malignant neoplasm of rectum. R19's admission Minimum Data Set (MDS) dated 5/1/17, indicated R19 had intact cognition and required physical assistance with bathing. The MDS further indicated it was very important for R19 to choose between a tub bath, shower, bed bath or sponge bath. R19's initial care sheet dated 4/24/17, directed 1 staff to participate with bathing. However, the	F 242	Patient was not informed that she had a choice for number of baths per week or which she preferred baths vs showers was not clear on the care plan. On May 24th Patient was informed that she has a choice between bath or showers. She was given the choice to pick days and times of baths/showers. Patient did decide to have baths 2x weekly and wanted it changed to Tuesday/Thursday. This was put on her care plan and on the bath list. She did not want any others scheduled but instead wanted to inform us when she wanted additional baths/showers at the time of need. Written and verbal education given to staff on June 5th on resident choices. Reminders will be given at monthly lane meetings and as needed x 3 months Changes were made on the bath list stating- Please offer a choice of bath or shower. The admission worksheet was updated to remind the nurse to inform residents of choices, all are now being asked what day/time they prefer a bath, how often and choice on bath or shower. Care plan will be updated by the nurse and the bath schedule will be updated by Health information. A copy of the Resident Bill of Rights is located in each room on the Transitional Care Unit in the resident handbook, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING _____ B. WING _____	05/24/2017

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 242	Continued From page 2 care sheet did not list the number or type of bath/shower to provide each week. The care sheet had bath tub and shower checked, however, did not indicate R19 preferred a bath. The facility form titled TCU Group List sheet, undated, instructed staff to provide R19 a bath on Wednesday a.m. The facility form title TCU Weekly Bath List dated 2/23/17, had a completed room number list of the entire wing with pre-populated dates and shifts of scheduled baths. When interviewed on 5/23/17, at 8:50 a.m. nursing assistant (NA)-G confirmed R19 received one bath a week. NA-G stated it was facility protocol to only offer residents one bath or shower each week, and stated each resident was assigned to a certain day of the week and time of day according to their room number. NA-G confirmed there was only one other resident in the entire unit that received more than one bath each week, and was not sure how that happened. When interviewed on 5/23/17, at 11:49 a.m. registered nurse (RN)-C reported the admission nurse informed all new residents the standard was for one bath or shower each week, and confirmed staff do not inform the residents that they can have multiple showers or baths in a week. RN-C stated residents could choose if they prefer a bath or shower and that was indicated on the initial care plan. RN-C stated R19 indicated it did not matter if she received a bath or shower, therefore, both were checked on the initial care sheet. RN-C confirmed frequency of bathing was not a choice, and was not documented.	F 242	posted on the Long Term Care lanes for all residents to view. It is verbally reviewed at resident council meetings. Interdisciplinary Team will discuss choices during weekly rounding meeting with the resident present and as needed on Transitional Care Unit. Changes will be made as requested by resident to the care plan. Long Term Care-social services are asking residents if they would like changes made to bath/showers and offering choices and it will be addressed quarterly at care conferences and as needed. Changes to bath schedule will be made as needed to accommodate choices made. Admission worksheets on Transitional Care Unit are kept by the Nurse Manager and checked during weekly Interdisciplinary Team rounding meetings that choices were offered and being followed. Audits will be done weekly x 4 weeks then monthly x 3 months. This will be brought to QAPI meeting after 3 months and determined if continued monitoring is needed based on findings. Responsible Parties DON/Nurse managers/Social Services	

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	245489	A. BUILDING _____ B. WING _____	05/24/2017

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F 242	Continued From page 3 When interview on 5/24/17, at 12:01 p.m. the director of nursing (DON) reported all residents were expected to have a choice of bed baths, showers or tub baths, and up to as many times per week as they desire. The DON confirmed each resident had the right to be informed of these options and would be documented on the bath list. The facility's Resident Choices Policy dated April 2017, indicated all residents would have the ability to choose care provided. The policy indicated staff would follow standard care of nursing policy, follow Resident Bill of Rights, notify on admission regarding choices and during care conferences and as needed, and document set changes on care plan and worksheets.	F 242		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 356		6/5/17

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F 356	Continued From page 4 vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nursing staff posting information included the correct daily census in the facility. In addition, the facility failed to maintain the posted daily nurse staffing information for a minimum of 18 months in the facility. This had the potential to affect all 97 current residents and any visitors in the facility.	F 356	F356 POSTED NURSE STAFFING INFORMATION Staffing and census was not updated daily. Postings were not kept for 18 months. The Policy and procedures were revised	

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F 356	Continued From page 5 Findings include: During the initial tour on 5/21/17 at 1:09 p.m. the nursing hours posting was observed in a clear plastic sleeve, secured to a wall directly in front of the wall coming from the long term care hallway to the transitional care unit. The posting dated 5/20/17, included the required nurse hours and categories, however, the required information was for 5/20/17. At 3:53 p.m. the staff posting was changed to reflect current date of 5/21/17, although the current census was listed as 98, and the facility had a current census of 97. During observation on 5/24/17 at 3:07 p.m. the nursing hours posting was observed in a clear plastic sleeve, secured to a wall directly in front of the wall coming from the long term care hallway to the transitional care unit. The posting included the required nursing hours and categories, however, the current resident census was incorrectly list as 97. The facility identified the current census for 5/24/17 was 99. Review of the facility daily nursing hour postings dated 4/22/17 - 5/24/17 revealed the facility had not updated the accurate daily census and the facility was unable to provide for review 11 out of the 32 staff postings for the time period from 4/22/17 to 5/24/17. On 5/24/17 at 2:52 p.m. director of nursing (DON) confirmed the nurse staff postings were inaccurate. The DON indicated the staffing coordinator was responsible for filling out the nurse staff posting form, posting it during week days and the nurse manager was responsible for updating the form on the weekends. The DON	F 356	on 6/1/17 to update who is responsible. Staffing coordinator prints off a new staffing and census daily and post. In the case of staff call in she/he is responsible for updating hours as it changes Monday –Friday. Medical records is responsible for updating planned admits/discharges M-F. Nurse Managers/PM supervisor are updating unplanned census changes(ER transfers etc). Weekends and holidays-Nurse Manager or designee is responsible for making census and staffing changes. When updating cross off with one line and write correct numbers in do not reprint. Postings are kept by staffing coordinator for 18 months. DON/ADON will audit weekly x 4 then monthly x 3 months that changes are updated and being kept by staffing coordinator. After 3 months it will be discussed in QAPI meeting and based on findings, determine if spot checks need to be continued or any other changes needed. Education given to Staffing Coordinator, medical records personnel and Nurse Managers on June 5th regarding responsibilities. Responsible Party: DON	

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F 356	Continued From page 6 indicated she would expect staff to include the current census on the form, and to update the form daily as needed with changes to the information. The DON verified the resident census had not been updated on the daily nursing staff data postings and confirmed the facility was unable to locate the previous postings for the facility. Review of the facility policy titled, Direct Nursing Hour Posting, revised on 11/16, indicated the direct hour posting will include: name of facility, date, census, total number and actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care each shift (RN, LPN, NAR). The policy also indicated the posting would be updated each shift and daily postings would be maintained for 18 months.	F 356		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		6/5/17

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F 431	Continued From page 7 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure prescribed medications were secured and monitored in	F 431	F431 DRUG RECORDS, LABEL STORE DRUGS & BIOLOGICALS	

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F 431	Continued From page 8 accordance with current professional standards on 1 of 3 units (transitional care unit)(R46, R171) of the facility. Findings include: On 5/21/17, at 4:35 p.m. a sealed box of prescribed Latanoprost eye drops with labeled instructions to Instill 1 drop in both eyes at bedtime for Glaucoma, dated, 2/20/2017 was observed in R46's unlocked refrigerator located in R46's bedroom on the transitional care unit. On 5/22/17, at 3:31 p.m. R46 was observed sitting in his recliner in his bedroom, prescribed medication continued to be unsecured in the unlocked refrigerator directly across from R46's recliner. On 5/21/17, at 4:40 p.m. a partially used bottle of prescription liquid omeprazole 2mg/ml give 20mg via G-tube with labeled instructions for one time a day every other day for GI prophylaxis for two weeks Discontinue after 2 weeks if no symptoms, dated 4/11/17 was observed in R171's unlocked refrigerator located in R171's bedroom in the transitional care unit. On 5/23/17, at 7:20 a.m. R171 was observed in bed in her bedroom, prescribed omeprazole continued to be unsecured in the unlocked refrigerator directly across from R171's bed. Nursing assistant (NA)-H and nursing assistant (NA)-I was observed in R171's room providing morning cares. During interview on 5/21/17, at 7:09 p.m. registered nurse (RN)-C verified all residents have locked drawers in their room that medications were to be secured in. RN-C indicated the facility owned the refrigerators in all of the residents rooms in the transitional care unit	F 431	Medications were found in two resident's personal refrigerators. Medications were removed from resident's refrigerator and placed in locked medication room refrigerator. All rooms were checked on 5/23/17 and there were no other rooms with medications in the refrigerator. A note was added to the admission check list to inform residents and families that all medications should be given to the nurse and not put in room or refrigerator unlocked. Staff education on June 5th included information on medication storage. All medications need to be locked up appropriately. A sign was placed on all personal refrigerators on 5/23/17 stating that all medications need to be given to the nurse. Transitional care handbook was updated on 5/23/17 stating not to keep medications in resident refrigerators. Admission worksheets are now being handed in to Transitional Care Clinical Nurse Manager for audit. Audits will be done weekly x 3 weeks then monthly x 3 months by Clinical Nurse Manager. After 3 months this will be brought to QAPI meeting and based on findings	

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F 431	Continued From page 9 of the facility. During interview on 5/23/17, 9:51 a.m. licensed practical nurse (LPN)-A confirmed all medications were to be stored in the locked drawer or locked cupboard in each resident room. LPN-A entered R171's room with surveyor to visualize the refrigerator and she confirmed R171's prescribed omeprazole was in the unsecured refrigerator. LPN-A was not aware the prescribed medication was in the unsecured refrigerator, and stated the medication had been recently discontinued and the usual facility practice was to destroy discontinued medication in the medication room. LPN-A confirmed the prescribed medication should not have been stored in the refrigerator, not secured. During interview on 5/23/17, RN-C was not aware of the prescribed medication in R46's bedroom refrigerator, and stated she felt R46's wife may have placed the medication in the unlocked refrigerator. RN-C confirmed all medications should be secured in the locked drawers or locked cupboards. RN-C stated any medication which required refrigeration should also be locked up in the medication storage area in the medication room. RN-C confirmed anyone who enters the resident rooms would have access to the prescription medications as the refrigerator are not secured. RN-C reported the resident refrigerators were not routinely monitored for appropriate temperatures or cleaned, and stated the only time staff checked the refrigerators is when housekeeping cleaned them when a resident moves out and a new resident moves in. During interview on 5/24/17, at 12:01 p.m. the director of nursing(DON) reported all prescription	F 431	determine if this needs to continue longer. Responsible Parties: DON/Clinical Nurse Manager TCU	

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F 431	Continued From page 10 medication was expected to be locked and secured in resident rooms, and would not be acceptable to be stored in the unlocked refrigerators. The DON confirmed residents were expected to routinely clean out the refrigerators, housekeeping cleaned the refrigerators upon discharge, and verified staff do not routinely check the refrigerators in resident rooms. The DON verified the consulting pharmacist checked for medication storage in the medication room and medication cart every month, but did not check the individual resident room refrigerators. The facility's Storage of Medication Policy dated August 2016, indicated medications would be stored in a safe, secure and orderly manner. The policy indicated compartment containing medications would be locked when not in use.	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 - Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey Emmanuel Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code NFPA 99 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2017

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	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by email to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 addition to the east wing was constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was

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K 000	Continued From page 2 determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111) construction. In 2004 a separate building (building 02) was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated form the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. In 2014 the Transitional Care was added and was determined to be of Type II (111) construction. The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code". The 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations. The facility has a capacity of 102 beds and had a census of 99 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133	NFPA 101 Multiple Occupancies - Construction	K 133		6/30/17

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K 133 SS=E	Continued From page 3 Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the protective opening rating in one of five 2 hour fire barriers as listed in the Life Safety Code NFPA 101 2012 edition, table 8.3.4.2. This deficient practice could cause fire to spread more quickly through a compartment and affect 39 of the 99 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 05/24/2017 observations and staff interview revealed the cross corridor doors in the 2 hour fire barrier separating the long term care wing does not have 90 minute doors. This deficient condition was confirmed by the Environmental Director.	K 133	F-133 The 60 minute fire barrier doors leading into the Long Term Care entrance will be replaced with 90 minute rated doors. An estimate has been received from Fargo Glass and Paint Co. and sent in for approval. These doors have a 3-4 week lead time from date of order. Persons Responsible: Environmental Director, will be responsible to ensure all of the above corrections are completed.	

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**05/24/2017**

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K 281	Continued From page 4	K 281		
K 281 SS=E	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient practice could reduce the illumination of the exits and affect 30 of the 99 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 05/24/2017 observations and staff interview revealed the east exit door of the temporary care unit does not have illumination that will provide lighting from more than one source. This deficient condition was confirmed by the Environmental Director.	K 281	K281 - The single lightbulb exit fixture exiting the Transitional Care Unit east exit has been replaced with a multiple LED light wall pack. Persons Responsible: Environmental Director, will be responsible to ensure all of the above corrections are completed.	5/31/17
K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control	K 341		5/31/17

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K 341	Continued From page 5 unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 05/23/2017 observations and staff interview revealed a smoke detector in a soiled utility room in the temporary care unit is too close to a heat diffuser. This deficient condition was confirmed by the Environmental Director.	K 341	K341- The ceiling smoke detector has been relocated in the Soiled Utility Room on the Transitional Care Unit so that it is 36 inches away from the ceiling heat diffuser. Persons Responsible: Environmental Director, will be responsible to ensure all of the above corrections are completed.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		6/16/17

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K 363	Continued From page 6 hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide a pair of corridor doors with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of	K 363	K363- The horizontal sliding doors will be removed from the linen storage closet on the Long Term Care Wing along with the shelving and linen being relocated. This compartment will be open to the hallway corridor and used for patient lifts.	

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K 363	Continued From page 7 fire, affecting 39 of the 99 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 3:00 pm on 05/24/2017 observations and staff interview revealed a pair of horizontal sliding doors on a clean linen room in the long term care wing do not positively latch or resist the passage of smoke. This deficient condition was confirmed by the Environmental Director.	K 363	Persons Responsible: Environmental Director, will be responsible to ensure all of the above corrections are completed.	