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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O7CX

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 **06/16/2015** (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 **112** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Tammy Williams, HFE NEII — 06/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/22/2015 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/25/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5489

On June 16, 2015, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 20, 2015. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of June 8, 2015. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on May 20, 2015, as of June 16, 2015. As a result of the revisit findings, the Department discontinued the Category 1 remedy of state monitoring effective June 16, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 26, 2015, be rescinded. (42 CFR 488.417 (b))

In our letter of May 28, 2015, we advised the facility that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 26, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance on June 16, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. Refer to the CMS 2567b for health only

Effective June 16, 2015, the facility is certified for 112 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24 5489

June 22, 2015

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

Dear Ms. Green:

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

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

Effective June 16, 2015 the above facility is certified for:

112 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 22, 2015

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

RE: Project Number S5489023

Dear Ms. Green:

On May 28, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 2, 2015. (42 CFR 488.422)

On May 28, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred and imposed the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 26, 2015. (42 CFR 488.417 (b))

Also, in our letter of May 28, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 26, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on March 26, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on May 20, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 16, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 8, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on May 20, 2015, as of June 16, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 16, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 26, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 26, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 26, 2015, is to be rescinded.

In our letter of May 28, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 26, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 16, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing	6/16/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	06/16/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	06/16/2015	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 GA/mm	Date: 06/22/2015	Signature of Surveyor: 32603	Date: 06/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/26/2015		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: O7CX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00013

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245489**
2.STATE VENDOR OR MEDICAID NO.
(L2) **726040700**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/20/2015** (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 **112** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 05/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/15/2015 (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
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
05/19/2015
(L33)

Posted 06/17/2015 Co.

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5489

On May 20, 2015, a Post Certification Revisit (PCR) was completed at this facility to verify the facility had achieved and maintained compliance with Federal certification requirements. Based on our revisit, we have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to the March 26, 2015 standard survey. The deficiencies not corrected are as follows:

- F0282 - S/S: D - D - 483.20(k)(3)(ii) -- Services By Qualified Persons/Per Care
- Plan F0323 - S/S: D - 483.25(f) -- Free of Accident Hazards/suervisions/devices

As a result of this revisit, and finding that the facility did not achieve substantial compliance, this Department imposed State monitoring, effective June 2, 2015.

In addition, this Department recommended to the CMS Region V Office, they concurred with our recommendation and is imposing the following remedy and has authorized this Department to notify the facility of the imposition:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions (DPNA), effective June 26, 2015. (42 CFR 488.417 (b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginning June 26, 2016.

Refer to the CMS 2567b for health and life safety code and CMS 2567 for health along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 28, 2015

MsJanetGreen, Administrator
Emmanuel Nursing Home
1415 Madison Avenue
Detroit Lakes, Minnesota 56501

RE: Project Number S5489023

Dear Ms. Green:

On April 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 26, 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 May 20, 2015, the Minnesota Department of Health and on May 19, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 26, 2015. The deficiencies not corrected are as follows:

F0282 - S/S: D - 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0323 - S/S: D - 483.25(h) -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective June 2, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for

new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 26, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 26, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 26, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Emmanuel Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 26, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than

sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 September 26, 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 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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 _____	R 05/20/2015

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 An onsite post certification revisit (PCR) was completed on 5/19/15 and 5/20/15. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 3 resident (R57) related to call light safety to prevent accidents. Findings include:	{F 282}	F282 services by qualified persons/per care plan Call light for R57 was assessed and removed from his room. A plug was placed in the wall socket and a sign was posted in the room to prevent re-introduction of the call light. A per-shift	6/8/15

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

Electronically Signed | 05/28/2015

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 _____	R 05/20/2015

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 282}	Continued From page 1 R57's annual Minimum Data Set (MDS) dated 3/3/15, identified R57 had severe cognitive impairment and required total assistance with all activities of daily living (ADLs) except for eating. The MDS also identified R57 to have a diagnosis of dementia and Parkinson's disease. R57's care plan dated 3/5/15, identified R57 had sleep disturbance, dementia, history of falls and paralysis agitans (Parkinson's disease). R57's care plan also identified R57 was able to fall out of bed, and to be sure R57 did not have the call light in bed with him due to a history of getting the call light wrapped around his neck. R57's care plan specifically directed staff to place the call light within reach when R57 was sitting up in the chair only, and was best to pin the call light around the arm of the chair. On 5/19/15, from 1:10 p.m. to 2:15 p.m. R57 was observed lying on his back in bed, covered with a blanket up to his chest. R57's call light with cord was attached to the sheet with a metal clip directly to the left side of R57's body, within reach. On 5/19/15, at 1:24 p.m. nursing assistant (NA)-B confirmed she assisted R57 to bed after lunch. NA-B stated R57 can safely have the call light while in the chair and bed, and said they clip it to something so it is secure for him to use. NA-B stated staff have a care plan which states what each resident needs and also reported she received education regarding the call lights. On 5/19/15, at 2:09 p.m. trained medication aide (TMA)-A stated she believed R57 was suppose to only have the call light while in the chair as far as she knew. TMA-A then stated R57 has chewed	{F 282}	check was added to the nurses MAR to ensure compliance on all residents who do not have a call light. Education on reading and following the care plan was provided by the clinical RNs to all direct care staff members house-wide. All care plans were reviewed and will continue to be reviewed for accuracy on a monthly basis and with the MDS schedule and with significant changes in condition. Weekly audits are to be completed by Clinical and MDS RNs, ADON, DON and Administrator. Ongoing compliance: Concerns will be immediately handled and brought to the QAPI meeting for discussion and to determine further interventions to ensure on-going compliance for all residents. Responsible Parties: Clinical RNs, MDS RNs, ADON, DON, and Administrator	

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 _____	R 05/20/2015

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 282}	Continued From page 2 on the call light cord before and we feel he should not even have it, he does not use it appropriately. TMA-A was not aware of R57's history of wrapping the call light around his neck. At 2:15 p.m. TMA-A walked down to R57's room, confirmed the call light was still in the bed and within R57's reach, then removed the call light from the bed. On 5/19/15, at 2:19 p.m. registered nurse (RN)-A stated R57 was only to have the call light when up in the wheelchair, and was not have the call light at all while in the bed. On 5/19/15, at 11:45 p.m. the director of nursing (DON) stated the staff re-assessed the call light use while in the bed for R57, and was found to be unsafe as R57 began to chew on the call cord. On 5/19/15, at 2:43 p.m. the DON confirmed the R57 should not have the call light in the bed, was unsure why the staff would have placed the call light in the bed as they had the education, plus R57's care plan information is available in the staff's hand held device that they can look at any time. The facility's Care Plan/Kardex IDT policy dated 11/14, indicated the care planning process is to assure that the resident along with the entire care team is involved in the care planning process to assure that care is planned to attain or maintain the resident's highest practicable physical, mental and psychosocial well being.	{F 282}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	{F 323}		6/8/15

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 _____	R 05/20/2015

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 323}	Continued From page 3 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident safety when 1 of 1 resident (R57) was given a call light after the facility had assessed it was not safe for R57 to have while in bed. Findings include: R57's annual Minimum Data Set (MDS) dated 3/3/15, identified R57 had dementia, severe cognitive impairment and required total assistance with all activities of daily living (ADLs) except for eating. R57's care plan dated 3/5/15, identified R57 should not have the call light in bed with R57 due to history of getting the the call light wrapped around the neck. R57's care plan specifically directed staff to place the call light within reach when R57 was sitting up in the chair only, and was best to pin the call light around the arm of the chair. On 5/19/15, from 1:10 p.m. to 2:15 p.m. R57 was observed lying on his back in bed, covered with a blanket up to his chest. R57's call light with cord was attached to the sheet with a metal clip directly to the left side of R57's body, within reach.	{F 323}	F323 Free of accidents hazards/supervision/devices Call light for R57 was assessed and removed from his room. A plug was placed in the wall socket and a sign was posted in the room to prevent re-introduction of the call light. A per-shift check was added to the nurses MAR to ensure compliance on all residents who do not have a call light. Education on reading and following the care plan was provided by the clinical RNs to all direct care staff members house-wide. All care plans were reviewed and will continue to be reviewed for accuracy on a monthly basis and with the MDS schedule and with significant changes in condition. Weekly audits are to be completed by Clinical and MDS RNs, ADON, DON and Administrator. Ongoing compliance: Concerns will be immediately handled and brought to the QAPI meeting for discussion and to determine further interventions to ensure on-going compliance for all residents.	

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 _____	R 05/20/2015

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 323}	Continued From page 4 On 5/19/15, at 1:19 p.m. nursing assistant (NA)-A reported R57 does not use the call light intentionally, further NA-A stated R57 did make the call light go on today because he was playing with it, but was not intentional. NA-A reported R57 should have the call light while in the chair only, not while in the bed. NA-A confirmed she assisted R57 to bed today with another staff member, and also confirmed R57's call light was placed in the bed with him and attached to the sheet within his reach. At that time NA-A did not remove the call light from R57's bed. On 5/19/15, at 1:24 p.m. NA-B confirmed she assisted R57 to bed after lunch. NA-B stated R57 can safely have the call light while in the chair and bed, and said they clip it to something so it is secure for him to use. NA-B stated staff have a care plan which states what each resident needs and also reported she received education regarding the call lights. On 5/19/15, at 2:09 p.m. trained medication aide (TMA)-A stated she believed R57 was suppose to only have the call light while in the chair as far as she knew. TMA-A then stated R57 has chewed on the call light cord before and they feel he should not even have it, and he does not use it appropriately. TMA-A was not aware of R57's history of wrapping the call light around his neck. At 2:15 p.m. TMA-A walked down to R57's room, confirmed the call light was still in the bed and within R57's reach, then removed the call light from the bed. On 5/19/15, at 2:19 p.m. registered nurse (RN)-A stated R57 was only to have the call light when up in the wheelchair, and was not have the call light	{F 323}	Responsible Parties: Clinical RNs, MDS RNs, ADON, DON, and Administrator	

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 _____	R 05/20/2015

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 323}	Continued From page 5 at all while in the bed. On 5/19/15, at 11:45 p.m. the director of nursing (DON) stated the staff re-assessed the call light use while in the bed for R57, and was found to be unsafe as R57 began to chew on the call cord. The DON stated at that time R57 could have the call light while up in the chair, but was not safe to have the call light while in bed, which was reflected in R57's current care plan. The DON stated the staff anticipate R57's needs as they are up and down the hallways often. On 5/19/15, at 2:43 p.m. the DON confirmed R57 should not have the call light in the bed, was unsure why the staff would have placed the call light in the bed as they had the education, plus R57's care plan information is available in the staff's hand held device that they can look at any time. The facility's Safety and Supervision of Residents policy revised December 2007, identified that employees will be trained and inserviced on potential accident hazards, and try to prevent avoidable accidents. The policy also identified the facility strives to make the environment as free from accident hazards as possible, with resident safety, supervision and assistance to prevent accidents are facility-wide priorities.	{F 323}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing	5/20/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **04/15/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/15/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/15/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/15/2015**	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

Reviewed By State Agency	**Reviewed By** PK/mm	**Date:** 05/28/2015	**Signature of Surveyor:** 32603	**Date:** 05/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/26/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing **01 - 2004 BUILDING 2008 KITCHEN ADDITI**	5/19/2015

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

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/26/2015**	ID Prefix	Correction Completed **03/26/2015**	ID Prefix	Correction Completed **03/30/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0022	
ID Prefix	Correction Completed **03/26/2015**	ID Prefix	Correction Completed **03/30/2015**	ID Prefix	Correction Completed **04/13/2015**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0056	
ID Prefix	Correction Completed **03/30/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0074		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	05/28/2015	27200	05/19/2015
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?	YES	NO
3/25/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing **02 - 1963 MAIN BUILDING**	5/19/2015

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

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/30/2015**	ID Prefix	Correction Completed **03/26/2015**	ID Prefix	Correction Completed **03/26/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0052		LSC K0056		LSC K0073	
ID Prefix	Correction Completed **03/26/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	05/28/2015	27200	05/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/25/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing **03 - BUILDING 3**	5/19/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/30/2015**	ID Prefix	Correction Completed **03/26/2015**	ID Prefix	Correction Completed **03/30/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0029		LSC K0052	
ID Prefix	Correction Completed **03/25/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0067		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	05/28/2015	27200	05/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/25/2015

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: O7CX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00013

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/26/2015** (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 **112** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Bernstetter, HFE NEII 05/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/15/2015 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/19/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 8, 2015

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

RE: Project Number S5489023

Dear Ms. Green:

On March 26, 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:

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:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: pam.kerssen@state.mn.us

Telephone: (218) 308-2129
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 5, 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 May 5, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 June 26, 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 September 26, 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

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

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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 _____	03/26/2015

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	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor residents choice for uninterrupted sleep for 1 of 2 residents (R32) reviewed for choices in daily routines. Findings include: R32's quarterly Minimum Data Set (MDS) dated 1/18/15, identified R32 had diagnoses of dementia, traumatic brain injury (TBI), anxiety,	F 242	One resident who wanted to sleep in was interrupted for medications, turning and repositioning and with housekeeping entering his room. Residents were interviewed by Social Services and choices were confirmed and documented on the plan of care. Staff members from all departments were re-educated on the importance of honoring choices, including not entering resident□s rooms, allowing	4/15/15

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

Electronically Signed | 04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 1 depression, and post traumatic stress disorder (PTSD). The MDS also identified R32 had moderate cognitive impairment, required extensive assist with all activities of daily living (ADL) except for eating. R32's annual MDS assessment dated 4/28/14, identified that choosing his bedtime was very important to him. R32's care plan identified that R32, "likes to sleep in," and R32, "may sleep in and have medications when awake." On 03/25/15, at 7:58 a.m. R32 was in bed, asleep with covers over his head. Licensed practical nurse (LPN)-C entered R32's room and called R32's name to wake him up. LPN-C gave R32 his morning medications, turned off the bedroom light, left the room and closed the door. On 03/25/15, at 8:16 a.m. R32 was observed in bed asleep with his head under the covers. The room was quiet and dark, the door was closed. On 03/25/15, at 8:18 a.m. nursing assistant (NA)-B entered R32's room after stating R32 was still sleeping and had not been up yet. NA-B entered R32's room and woke R32 up to offer breakfast items. NA-B then told R32, "It's your choice if you want to get up or not." NA-B proceeded to tell R32 she was going to raise his bed up. NA-B left R32's room with a trash bag after changing R32's incontinent product, and stated R32 wanted to sleep in. On 03/25/15, at 8:27 a.m. housekeeper (HSK)-A and HSK-B entered R32's room with a large utility cart and began to clean R32's room. HSK-A and HSK-B were closing drawers, shutting closets, wiping off bedroom door and making a lot of loud,	F 242	the resident to sleep. Care plans were reviewed, updated and reviewed with all staff members who enter resident rooms. Audits of honoring choices will be done via Social Services, RN Coordinators, DON, and Administrator on weekly basis X 4, 2X month X 4 months and then monthly X 4 at different times and days and documented on the computer audit sheet. Concerns will be immediately handled and brought to the QAPI meeting for discussion and to determine further interventions to ensure on-going compliance for all residents. Resident choice will be discussed at care conferences and updated on the plan of care quarterly. Monitoring of adherence with resident choice will be periodically asked during resident council meetings to ensure on-going compliance. Responsible Persons: Interdisciplinary team members: Social Workers, Life Enrichment Specialists, Clinical RN Coordinators, RN MDS coordinators, and Director of Nursing	

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EMMANUEL NURSING HOME	**1415 MADISON AVENUE DETROIT LAKES, MN 56501**

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F 242	Continued From page 2	F 242		

banging and clanging noises. R32's room smelled strong of cleaning solution.

On 03/25/15, at 8:29 a.m. HSK-A and HSK-B were asked about how they determine and prioritize what resident rooms to clean and when. HSK- A stated they use a running monthly checklist to clean resident rooms and stated they usually pick the rooms according to which residents have a bath that day or a beauty shop appointment that day. HSK-A stated they work around which rooms will be empty.

On 03/25/15, at 9:29 a.m. NA-B stated R32 likes to sleep in on average 3-4 days per week. NA-B stated it is typical for the LPN to wake R32 up to give him his morning medications. NA-B stated she repositioned R32 and changed his brief that morning while he was trying to sleep in bed. NA-B stated it was typical to reposition and change R32's brief before breakfast while R32 was asleep.

On 03/25/15, at 9:44 a.m. LPN-C stated it was typical for R32 to sleep in. LPN-C stated if R32 wants to sleep in, you just leave him alone or he accelerates and has tantrums quickly. LPN-C stated R32 likes to sleep in 2-3 times per week. LPN-C stated it was typical to wake R32 to give him his medications.

On 03/25/15, at 9:51 a.m. HSK-A stated they clean R32's room everyday, 365 days a year. HSK-A stated it is typical for them to clean R32's room when he was in bed sleeping. HSK-A stated R32 sleeps a lot and stated, "We go in several residents rooms to clean when they are sleeping, if we waited for everyone to be up, we would be here all day." HSK-B only nodded in agreement

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F 242	Continued From page 3 during the interview. On 03/26/15, at 9:32 a.m. registered nurse (RN)-E stated she was not aware that the LPN had been waking R32 up to give him his medications when he prefers to sleep in. RN-E stated to maintain quality of care they would wake R32 up to reposition and change his brief. RN-E stated she was not aware that housekeeping cleaned R32's room while he was trying to sleep. RN-E stated if she was aware she would have stopped it and stated that this is R32's home. RN-D stated it was policy to turn every resident every 2 hours. RN-D stated that R32 was checked and changed every 2 hours, even in the middle if the night. RN-E placed a call to medical records to inquire if a sleep study had been done for R32 over the last year, the facility had not evaluated his sleep patterns to individualize his care. RN-D confirmed R32's annual MDS assessment dated 4/28/14, indicated choosing his bedtime was very important to him. On 03/26/15, at 11:26 a.m. R32 stated he would like to sleep in. R32 stated, "Staff sometimes try to wake me up, and I try to sleep." R32 stated he likes sleeping and gets bothered by staff. R32 stated he told staff he doesn't like to be woke up. R32 stated, "When the staff wake me up I don't feel rested." R32 stated he's tired during the day because the staff wake him up. R32 stated, "I try to make up for it during the day." R32 stated staff wake him up for pills, to change him, move him in bed and to clean his room. R32 stated he tells staff to leave him alone. R32 stated if he had his choice, he would like to sleep all night. R32 stated, "It would be great if they would let me sleep all night until I woke up." R32 stated he wanted the nurses, NAs and housekeepers to	F 242		

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F 242	Continued From page 4 stay out of his room until he wakes up. R32 stated, "Would you tell staff, if I'm sleeping, let me sleep." An undated facility policy titled Quality of Life-Self Determination and Participation Policy identified each resident shall be allowed to choose activities, schedules and health care that are consistent with his or her interests, assessments and plans of care, including daily routine, such as sleeping.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		4/15/15

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F 279	Continued From page 5 Based on observation, interview and document review, the facility failed to develop a care plan for 1 of 3 residents (R95) assessed as being dehydrated. Findings include: R95's quarterly Minimum Data Set (MDS) dated 2/19/15, identified R95 had severe cognitive impairment and was dehydrated. R95's care plan dated as reviewed on 3/6/15, lacked any indication of R95's condition of dehydration. A nursing assessment dated 2/19/15, identified R95's indicators of dehydration by the following, cheeks pale bilaterally, needed much encouragement to eat and drink, refused food and fluids most of the time, constipation, skin dry, tenting was evident, hydration risk and fluid intake of less than 50%. The nursing assessment also identified R95 as needing supervision for eating. During observation on 3/25/15, at 9:07 a.m. R95 was sitting in a wheelchair propelling up and down the east hall with both feet. R95's lips had dry, flaky skin on the left side of the lower lip. During observation on 3/26/15, at 9:35 a.m. R95 was lying in bed, eyes closed, right side of lips had dry, flaky skin. At 11:05 a.m. R95 was in a wheelchair, lips were dry as evident by flaky skin on top and bottom of lips. Registered nurse (RN)-D verified R95's lips were dry and flaky. During observation on 3/26/15, at 1:22 p.m. R95 was sitting in a wheelchair in personal room with flaky skin on bottom left side mouth, inside of	F 279	One resident, on end of life comfort measures, who was assessed via the RN Coordinator as being dehydrated did not have the dehydration listed on the care plan. Staff members were offering her fluids frequently during the day. The care plan was revised and staff members reviewed the new care plan. All care plans were reviewed for accuracy with the IDT members. Audits of the care plans for on-going compliance to ensure care plans are accurate and complete will be done with each quarterly assessment and with any significant change in condition. Any concerns will be brought to the QAPI meeting to review. Responsible Persons: Interdisciplinary team members including: Dietician, Social Workers, Life Enrichment Specialists, Clinical RN Coordinators, RN MDS Coordinators, and Director of Nursing.	

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 _____	03/26/2015

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F 279	Continued From page 6	F 279		

cheeks were observed to be pale during conversation with R95. An 8 ounce (oz) glass of water was observed to be on R95's bedside table, and R95 made no attempt to drink the water.

During an interview on 3/25/15, at 1:08 p.m. R95 stated she was doing well, was thirsty at times, but she gets enough to eat and drink.

During an interview on 03/26/15, at 9:11 a.m. nursing assistant (NA)-E stated R95 needed physical assistance with her activities of daily living. NA-E stated she had observed R95 to have a foul mouth odor at times and a dry mouth.

On 3/26/15 at 10:46 a.m. RN-D verified she had assessed R95 as being dehydrated based on the criteria of sunken eyes, no decent skin turgor, intake of less than 1500 milliliters (ml) of fluids daily, and concentrated urine. RN-D further confirmed R95's care plan lacked addressing dehydration and should have addressed it as it was an ongoing problem with R95 due to fluctuation in intake and willingness to accept assistance.

On 03/26/15, at 1:39 p.m. the director of nursing (DON) confirmed R95 should have had dehydration addressed in the care plan due to being assessed as dehydrated in order to monitor and implement interventions.

The Emmanuel Community policy and procedure titled, Care Plan/Kardex IDT, revised 11/14, reveled a policy of care planning to assure residents attained or maintained their highest practicable physical, mental and psychosocial well being. The policy further directed facility nursing staff to implement resident care plan

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EMMANUEL NURSING HOME	1415 MADISON AVENUE DETROIT LAKES, MN 56501

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F 279	Continued From page 7 based upon assessed needs, problems and conditions.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R93) reviewed in the sample for non-pressure related skin issues/bruising; and failed to follow the plan of care for 1 of 1 resident (R57) related to call light safety to prevent accidents. Findings include: R93's current diagnoses according to the Order Summary Report dated 2/9/15, revealed muscle weakness, lack of coordination, and malignant neoplasm prostrate. R93's most recent 30 day Minimum Data Set (MDS) dated 3/9/15, revealed R93 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R93's care plan dated 2/16/15, lacked any identified concerns with bruising or interventions related to skin injuries. Furthermore, the care plan indicated R93 had potential for bleeding related to anticoagulation therapy and staff were to monitor for ecchymosis (bruising). On 3/25/15, at 7:08 a.m. R93 was getting dressed for the day independently in his room. At 7:17 a.m. R93 was sitting in his wheel chair and was	F 282	One TCU resident who came from the hospital with multiple bruises on his arms related to IV sites and venous puncture sites did not have documentation of the nursing staff ensuring that the bruising was resolving. The system of placing the bath day into the computer for the nurse to visually check the resident□s skin during the bath failed to list the bath day. The system was changed to continue to alert the nurse to visually inspect the resident□s skin on admission and then at least every seven days. The one resident should have had his call light in his chair only due to safety concerns with his severe dementia and history of unsafe behavior with the call light when in bed. The NAR placed the call light on his bed. The care plan was reviewed with the NAR and all direct care staff members were re-educated to review, know and follow each residents care plan. Audits will be competed by the RN Clinical Coordinators, MDS Coordinators and the	4/15/15

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	245489	A. BUILDING _____ B. WING _____	03/26/2015

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

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F 282	Continued From page 8 noted to have multiple bruises of different shapes and sizes on his right and left hands and forearms that were dark purple/red in color. On 3/25/15, at 7:17 a.m. R93 confirmed that no one had hurt or abused him and stated, "I get them from bumping myself and stuff. " On 3/25/15, at 9:18 a.m. registered nurse (RN)-A confirmed R93 had multiple bruises on his hands and forearms and verified their was no documentation to support that staff was monitoring R93's skin and bruising on a weekly basis as ordered by the physician. On 3/25/15 at 9:18 a.m. RN-C and licensed practical nurse (LPN)-A confirmed R93 had multiple bruises on his hands and forearms and verified their was no documentation to support that staff was monitoring R93's skin and bruising on a weekly basis as ordered by the physician. On 3/26/15, at 10:07 a.m. the director of nursing (DON) confirmed R93 had multiple bruises on his hands and forearms and verified their was no documentation to support that staff was monitoring R93's skin and bruising on a weekly basis as ordered by the physician. R57's annual MDS dated 3/3/15, identified R57 had severe cognitive impairment, and required total assistance with all activities of daily living (ADLs) except for eating. The MDS also identified R57 to have a diagnosis of dementia and Parkinson's disease. R57's care plan dated 3/10/15, identified R57 had sleep disturbance, dementia, history of falls and paralysis agitans. R57's care plan also identified R57 was able to fall out of bed, and to be sure R57 does not have his call light in bed with him due to history of getting the call light wrapped around his head.	F 282	Director of Nursing. This audit will be done weekly basis X 4, 2X month X 4 months and then monthly X 4 and will report findings to the QAPI meeting to review. Random audits and on-going education will be completed to endure on-going compliance. Responsible Persons: Clinical RN Coordinators, Director of Nursing.	

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F 282	Continued From page 9 On 03/24/15, at 8:52 a.m. R57 was observed laying on his back, covered with a blanket up to his chest. R57's call light with cord was laying on top of his blanket to the left side of R57's chest within his reach. On 03/24/15, at 9:07 a.m. RN-D stated there wasn't a call light in R57's room because he had wrapped it around his neck before. RN-D stated R57 had a care plan for using his call light. RN-D stated R57 should not have had a call light in bed with him. On 03/24/15, at 9:12 a.m. RN-D and RN-E confirmed R57's call light was in bed with R57 and was on top of his blanket within his reach. RN-E removed the call light. RN-D stated the call light was not supposed to be in R57's bed, and should have been in his wheelchair. RN-D stated she would not want to see R57 get hurt. RN-D stated the staff place the call light in bed with R57 when he is in bed out of habit. The facility policy titled Care Plan/Kardex IDT identified the care planning process is to assure that the resident along with the entire care team is involved in the care planning process to assure that care is planned to attain or maintain the resident's highest practicable physical, mental and psychosocial well being. .	F 282		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bruising was assessed, monitored, and interventions implemented to prevent further bruising for 1 of 3 residents (R93) reviewed for non-pressure related skin conditions. Findings include: R93's current diagnoses according to the Order Summary Report dated 2/9/15, revealed muscle weakness, lack of coordination, and malignant neoplasm prostrate. R93's most recent 30 day Minimum Data Set (MDS) dated 3/9/15, revealed R93 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R93's care plan dated 2/16/15, lacked any identified concerns with bruising or interventions related to skin injuries. Furthermore, the care plan indicated R93 had potential for bleeding related to anticoagulation therapy and staff were to monitor for ecchymosis (bruising). R93's physician orders dated 2/9/2015, indicated the physician ordered the nurse to check skin condition every week on bath day and document any concerns in progress notes. R93's nursing assessment dated 2/9/15, 2/23/15 and 3/9/15, under skin issues, indicated R93 had	F 309	One TCU resident who came from the hospital with multiple bruises on his arms related to IV sites and venous puncture sites did not have documentation of the nursing staff ensuring that the bruising was resolving. The system of placing the bath day into the computer for the nurse to visually check the resident□s skin during the bath failed to list the bath day. The system was changed to the nurse to visually inspect the resident□s skin on admission and every seven days. Documentation will include nurse□s initials and charting to exception for noteworthy changes. Audits will be completed via the RN Clinical Coordinator on the TCU to ensure that documentation of the skin check is completed on a weekly basis. Audits will be done weekly X 4, 2X month X 4 months and then monthly X 4. Random audits will be completed to ensure on-going compliance throughout the nursing home. Findings will be reported to the QAPI meeting to review and encourage on-going compliance.	4/15/15

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F 309	Continued From page 11 bruises noted on right and left arms from intravenous sites. The documentation did not change from one nursing assessment to the other. R93's nursing progress note dated 2/9/15, indicated R93 had bruises noted on right and left arms from intravenous sites, although the nursing progress notes, treatment sheets and medication administration sheets from admission, lacked any other documentation regarding bruising injuries or monitoring of any areas for resolution. During observation on 3/25/15, at 7:08 a.m. R93 was getting dressed for the day independently in his room. At 7:17 a.m. R93 was sitting in his wheel chair and was noted to have multiple bruises of different shapes and sizes on his right and left hands and forearms that were dark purple/red in color. The multiple bruises on R93's hands and forearms appeared to be spreading out and almost covering his entire hands and forearms. During interview on 3/25/15, at 7:17 a.m. R93 confirmed that no one had hurt or abused him and stated, "I get them from bumping myself and stuff. " During interview on 3/25/15, at 9:18 a.m. registered nurse (RN)-A confirmed R93 had multiple bruises on his hands and forearms and verified there was no documentation to support that staff was monitoring R93's skin and bruising on a weekly basis as ordered by the physician. Nor were there interventions in place to prevent further bruising. During interview on 3/25/15, at 9:18 a.m. RN-C and licensed practical nurse (LPN)-A confirmed R93 had multiple bruises on his hands and forearms and verified their was no documentation to support that staff was monitoring R93's skin and bruising on a weekly basis as ordered by the	F 309	Responsible Persons: Clinical RN Coordinator, Director of Nursing	

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F 309	Continued From page 12 physician. RN-C and LPN-A stated they rely on the nursing assistants to tell them if a resident has a new bruise, and verified that they do not really monitor bruises and would not know if a resident had a new bruise from admission unless the nursing assistants tell them. During interview on 3/25/15, at 9:58 a.m. RN-B confirmed R93 had multiple bruises on his hands and forearms and verified their was no documentation to support that staff was monitoring R93's skin and bruising on a weekly basis as ordered by the physician. RN-B confirmed that R93's skin assessment since admission had not been changed and stated, "he does bruise easily and I would not be able to tell you which bruises are new or not." During interview on 3/26/15, at 10:07 a.m. director of nursing (DON) confirmed R93 had multiple bruises on his hands and forearms and verified their was no documentation to support that staff was assessing and monitoring R93's skin and bruising on a weekly basis as ordered by the physician. Review of facility policy titled, Pressure Risk and Skin Observation, revised on 11/14, indicated skin/pressure risk observation form will be done on first bath day and every bath day weekly x 4 weeks, and with significant change in status. The nurse on duty during bath time of that specific resident will complete task. The nurse will complete the weekly documentation and ensures proper treatment/interventions are implemented.	F 309		
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	F 323		4/1/15

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F 323	Continued From page 13 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident safety when 1 of 3 residents (R57) was given a call light after the facility had assessed it was not safe for him to have. In addition, the facility failed to ensure safe transportation of 1 of 1 residents (R53) who was observed to be propelled by staff while seated on a wheeled walker. Findings include: R57's annual Minimum Data Set (MDS) dated 3/3/15, identified R57 had dementia, severe cognitive impairment and required total assistance with all activities of daily living (ADLs) except for eating. R57's care plan dated 3/10/15, identified R57 should not have his call light in bed with him due to history of getting the call light wrapped around his head. On 03/24/15, at 8:52 a.m. R57 was observed laying on his back, in bed, covered with a blanket up to his chest. R57's call light with cord was laying on top of his blanket to the left side of R57's chest within his reach. On 03/24/15, at 9:07 a.m. registered nurse (RN)-D stated R57 should not have had a call light in bed with him because he had a history of it	F 323	One nurses used the seated 4 wheeled walker to bring a resident back to her room approximately 40 feet during a supper meal when the resident was not eating well. The nurse was re-educated on following the manufacturer□s guidelines for safety. Education was provided to all direct care staff members on the proper use of equipment including use of wheeled walkers with seats. The call light was removed from a room where the resident had a history over one year or so of being unsafe in using it when in bed. The care plan stated he should have the call light when in the chair only. The RN initiated a trial, allowing use of the call light back in his room with frequent checks to observe his response. He began to chew on the call light. The call light was again removed, documentation was completed and the care plan was updated. Direct care members were educated on the care plan and the safety concern with having the call light when in bed. Audits to ensure compliance with following plan of care for call lights and use of medical equipment will be done by RN Coordinators, DON, staff nurses, and Administrator on weekly basis X 4, 2X month X 4 months and then monthly X 4	

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F 323	Continued From page 14 being wrapped around his neck. On 03/24/15, at 9:12 a.m. RN-D and RN-E confirmed the call light was in bed with R57 and was on top of his blanket within his reach. RN-E removed the call light. RN-D stated the call light was not supposed to be in R57's bed, "I wouldn't want him to get hurt." RN-D stated the staff must have placed the call light in bed with R57 "out of habit." On 03/25/15, at 9:46 a.m. licensed practical (LPN)-C stated R57's call light was a safety hazard for R57 and he should not have it with him in bed. The facility policy titled Safety and Supervision of Residents, identified that employees will be trained and inserviced on potential accident hazards, and try to prevent avoidable accidents. The policy also identified the facility strives to make the environment as free from accident hazards as possible, with resident safety, supervision and assistance to prevent accidents are facility-wide priorities. R53's quarterly MDS dated 1/27/15, identified R53 had severe cognitive impairment and required extensive assistance with all ADLs except eating. R53 had a diagnoses of dementia, unsteady balance and utilized a walker. R53's care plan dated 3/11/15, identified R53 uses her own seated wheeled walker to maximize independence with transferring. The care plan also identified R53 would sometimes sit and have staff push her using her walker when she is unsteady.	F 323	at different times and days and documented on the audit sheet located in the computer. Any concerns will be immediately handled and brought to the QAPI meeting for review and to implement further interventions required to ensure on-going compliance. Responsible Persons: Clinical RN Coordinators, Director of Nursing, staff nurses.	

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F 323	Continued From page 15 On 03/23/15, at 6:09 p.m. R53 was seated in her wheeled walker and transported from the dining room to her room by RN-E. On 03/25/15, at 7:09 a.m. R53 was seated in her wheeled walker and transported to the dining room by NA-D. R53 was then transferred by nursing assistant (NA)-D into a dining room chair for breakfast. R53 then told NA-D she needed to use the bathroom. NA-D again transported R53 seated in her walker to her room to use the bathroom. On 03/25/15, at 8:40 a.m. R53 was seated in her wheeled walker and transported by NA-C to her room to use the bathroom. On 03/25/15, at 12:53 p.m. NA-D was observed pushing R53 backwards (NA-D and R53 were facing one another during the transport) while R53 was seated in her wheeled walker to R53's room. NA-D stated when R53 gets tired they push her using her wheeled walker. On 03/25/15, at 12:58 p.m. RN-E stated residents do ride on their wheeled walkers sometimes, and R53 was often transported by staff using her wheeled walker. On 03/25/15, at 12:59 p.m. NA-A stated sometimes R53's knees get weak and "we push her in her wheeled walker." During a telephone interview on 3/25/15, at 1:05 p.m. technician-A stated she had sold the seated wheeled walker, "Guardian wheeled walker, model# G07887R" to R53's family, however, she had not assessed if R53 was safe to be propelled	F 323		

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F 323	Continued From page 16 by staff while seated on the walker. Technician-A stated she thinks you can use the wheeled walker for transportation in the home or at the facility as long as the grounds are not bumpy. Technician-A stated she was looking at the manufacturer's booklet and it doesn't say anything about having anyone sit on it and be pushed, only that you can't sit on it and propel yourself. On 03/26/15, at 9:23 a.m. RN-E stated R53 was admitted with her own wheeled walker. RN-E stated R53 had been pushed while seated in her wheeled walker at the assisted living facility prior to her admission and the facility continued to transport R53 while she was seated in her wheeled walker. The Assembly, Installation and Operating Instructions was provided by Wheelchairs Unlimited on 3/25/15, at 3:03 p.m. via facsimile and identified that consumers are not to use the device as a wheelchair or transport device. "The device is not intended to be propelled while seated. The brakes must be in the locked position before using the seat." The facility policy titled Resident Safety, dated 1/04 identified that all staff members will follow the manufacturer's instructions for all medical devices or adaptive equipment to provide safety to all involved. Any deviations from the manufacturer's instructions will be reported immediately to the supervisor and the quality assurance committee for review.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		4/1/15

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F 431	Continued From page 17 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 schedule 2 controlled medications were secured under double locks for one of three medication rooms.	F 431	One nurse, one time, did not check to make sure the controlled substance drawer in the refrigerator was locked before she left the locked medication	

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F 431	Continued From page 18 Findings include: On 3/26/2105, at 2:09 p.m. an observation of the medication storage room for the long term care unit with registered nurse (RN)-F. The medication room held two standard refrigerators, one was used of resident beverages and the other used for medication storage. The medication fridge had a small drawer (generally used for meats and cheeses in a residential setting) with a keyed lock. Upon pulling on the drawer it opened and held nine vials of lorazepam (a schedule 4 controlled anti-anxiety medication) 2 mg/ml for injectable solution and two boxes each holding liquid morphine (schedule 2 controlled medication). On 3/26/2015, at 2:18 p.m. RN-F stated the drawer held lorazepam for the long term care units emergency kit as it had to be kept in the fridge and the morphine was for two residents on the unit. RN-F stated the drawer should have been locked due to the medication being stored in the drawer. She further stated the licensed nurses on the unit have keys to the medication room. RN-B reconciled the count of the medications due to the drawer being unlocked which revealed an accurate count. On 3/26/15, at 2:28 p.m. the director of nursing (DON) confirmed the drawer should have been locked in the medication room of the long term care unit due to the medication being stored in the drawer. A facility policy titled, Emmanuel Nursing Home policy and procedure for Narcotic- Counting Of/Storage Security Nursing, revised 11/2014.	F 431	room. The nurse was re-educated on the policy. Education was provided to all nurses and TMAs to always double lock all controlled substances medication cart, medication room, and refrigerators. Audits will be done via RN Coordinators, DON, and Pharmacy Consultant on weekly basis X 4, 2X month X 4 months and then monthly X 4 at different times and days and documented on the audit sheet located in the computer. Any concerns will be immediately handled and brought to the QAPI meeting to review. Random audits will be completed in all medication rooms to ensure on-going compliance. Responsible Persons: Clinical RN Coordinators, Director of Nursing	

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	245489	A. BUILDING _____ B. WING _____	03/26/2015

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 431	Continued From page 19 The policy directed facility nursing staff that all controlled substances needed to be double locked for security.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **03 - BUILDING 3** B. WING _____	**03/25/2015**

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
K 000	INITIAL COMMENTS FIRE SAFETY Building 03 - 2014 Transitional Care Unit Addition 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 Building 03 - 2014 Transitional Care Unit Addition was found not 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 18 New Health Care. 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		04/17/2015

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 **03 - BUILDING 3** B. WING _____	**03/25/2015**

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
K 000	Continued From page 1 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 or 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 facility was inspected as 3 buildings: The Emmanuel Nursing Home build a Transitional Care Unit addition in 2014 (building 03). The Transitional Care Unit is a 1 story with partial basement building that was determined to be of Type II (111) construction and separated with a 2-hour fire rated barrier. . The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes 30-foot on center	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **03 - BUILDING 3** B. WING _____	**03/25/2015**

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
K 000	Continued From page 2 corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code and the 1997 and 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 112 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 two hour fire separations that were found not in compliance with NFPA 101 "The Life Safety Code" (00) section 18.1.1.4.2. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect	K 011	A UL approved 90 minute brush sweep has been attached to the TCU entry doors. Door gap is now less than 1/8 inch. The door closer has been adjusted to provide a positive latch and seal. Environmental Services Director is responsible for on-going compliance.	3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **03 - BUILDING 3** B. WING _____	**03/25/2015**

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
K 011	Continued From page 3 all of the residents, staff and visitors of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations revealed that the 2 hour fire rated doors located in the TCU wing had a gap between the doors leaves that was greater than 1/4 of an inch and the doors did not positively latch into the door frame. This deficient condition was verified by the Maintenance Supervisor.	K 011		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 18.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors.	K 029	All door closures on all soiled utility rooms have been inspected and adjusted to provide a positive latch and seal. Periodic audits have been added to the preventative maintenance program to ensure on-going compliance. Environmental Services Director is responsible to ensure this correction is complete and for on-going compliance.	3/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **03 - BUILDING 3** B. WING _____	**03/25/2015**

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
K 029	Continued From page 4 Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observation revealed, that the fire rated door to the soiled utility rooms located by the Long Term Care building by the nurses station. This deficient practice was verified by the Maintenance Supervisor.	K 029		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility.	K 052	The alarm documentation for this section of the building was available for review. 1. Protection Systems, Inc. has provided annual testing documentation for the entire facility from their inspection on January 5, 2015. It has been added to our life safety documentation book. This was completed on 3/26/15. All annual inspection reports will be kept in the Life Safety book for easy access. 2. The smoke detector located in the LTC dining room was relocated on March	3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **03 - BUILDING 3** B. WING _____	**03/25/2015**

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

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K 052	Continued From page 5 Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, a review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection that the facility could not provide any current testing documentation for their fire alarm system. This deficient practice was verified by the Maintenance Supervisor.	K 052	30, 2015 so that it is now a minimum of 36 inches away from HVAC diffuser. 3. Environmental Services Director is responsible for on-going compliance.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99). This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of residents, staff and visitors in the event of a fire. Findings include: On facility tour between 9:00 AM to 3:00 PM on	K 067	The HVAC damper inspection cover was re-affixed to the duct work. Monthly inspections will take place to ensure there is not a latch issue. This was completed March 25, 2015. Environmental Services Director is responsible to ensure this correction is complete and for on-going compliance.	3/25/15

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	245489	A. BUILDING **03 - BUILDING 3** B. WING _____	**03/25/2015**

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EMMANUEL NURSING HOME	**1415 MADISON AVENUE** **DETROIT LAKES, MN 56501**

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K 067	Continued From page 6 03/25/2015, observations revealed that the HVAC damper inspection cover was missing from the duct work located above the ceiling tiles by the 2 hour separation between the existing building and the new Transitional Care Unit addition. This deficient practice was verified by the Maintenance Supervisor.	K 067		

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	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - 1963 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 Building 01 - 1963 Main Building was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 04/17/2015

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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	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us or 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 facility was inspected as 3 buildings: 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 determined to be of Type II (000) construction. In	K 000		

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	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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

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K 000	Continued From page 2 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 (building 02) 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 Unit (building 03) 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 1999 edition. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code and the 1997 and 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 112 beds and had a census of 87 at the time of the survey.	K 000		

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K 000	Continued From page 3 The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 3 of 3 two hour fire separations that were found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect all of the residents, staff and visitors of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations revealed the following 2 hour fire separations were not in compliance, 1) In the 2 hour fire separation by the coordinator's office there is a conduit located above the ceiling tile that is not plugged with approved intumescent caulking,	K 011	An extensive remodeling and construction project resulting in a significant number of wires being installed by numerous subcontractors. 1. Conduit pipe opening has been sealed using UL approved fire caulking. This was completed on March 26, 2015. 2. Conduit pipe penetrations have been sealed using UL approved fire caulking. This was completed on March 26, 2015. 3. A UL approved 90 minute brush sweep has been attached to Memory Care entry doors. Door gap is now less than 1/8 inch. This was completed on March 26, 2015. Environmental Director is responsible to ensure this correction is complete and for on-going compliance.	3/26/15

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K 011	Continued From page 4 2) In the 2 hour fire separation in the TeleServices room above the ceiling tiles there are penetrations around the conduit that is passing through that wall, and 3) The 2 hour fire rated doors located in the Memory Care wing had a gap between the doors leaves that was greater than 3/8 of an inch. This deficient condition was verified by the Maintenance Supervisor.	K 011		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018		3/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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
K 018	Continued From page 5 Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) section 19.3.6.3.2. This deficient practice could affect the safety of all residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, it was observed that Resident room 27 has a door that did not positively latch into the door frame. This deficient condition was verified by the Maintenance Supervisor.	K 018	The door frame in resident room 27 in the Memory Care wing has been adjusted to provide a positive latch and seal for the door. This was completed on March 26, 2015. Periodic audits of doors will be completed by Environmental Services staff for on-going compliance. Responsible person: Environmental Services Director and Administrator.	
K 022 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 3 of several non-required doors leading to the exterior that do not lead to the public way in accordance with	K 022	Signage to previous exit doors in the chapel and multi-purpose room have been changed to read No Exit. These doors are no longer exits due to attached deck no	3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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

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K 022	Continued From page 6 NFPA 101 (00) sections 7.10.1.7 and 7.10.8.1. These deficient practices could negatively affect residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations revealed that the chapel doors leading to the deck that does not lead to the public ways. These doors are not part of a required exits and need to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient practice was verified by the Maintenance Supervisor.	K 022	longer providing access to the parking lot. Environmental Services Director is responsible to ensure that this correction is complete. Environmental Services Director and Administrator to complete random audits to ensure appropriate signage is maintained to ensure on-going compliance. Responsible persons: Environmental Services Director and Administrator.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		3/26/15

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	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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
K 029	Continued From page 7 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observation revealed, that the fire rated door to the soiled utility rooms located by the Long Term Care building by the nurses station. This deficient practice was verified by the Maintenance Supervisor.	K 029	All door closures on all soiled utility rooms have been inspected and adjusted to provide a positive latch and seal. Periodic audits have been added to the preventative maintenance program to ensure a positive latch and seal is maintained. Environmental Services Director is responsible to ensure this correction is complete and for on-going compliance.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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

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K 052	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, the following deficient conditions were found affecting the facility's fire alarm system, 1) after a review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection that the facility could not provide any current testing documentation for their fire alarm system. 2) there is a smoke detector located in the "Gathering Place" that was located within 36 inches of a HVAC diffuser.	K 052	1. Protection Systems, Inc. has provided annual testing documentation for the entire facility from their inspection on January 5, 2015. It has been added to our life safety documentation book. This was completed on 3/26/15. All annual inspection reports of all areas of the building will be kept in the Life Safety book. 2. The smoke detector located in the LTC dining room was relocated so that it is now a minimum of 36 inches away from HVAC diffuser. This was completed on March 30, 2015. Environmental Services Director is responsible for on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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

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K 052	Continued From page 9 This deficient practice was verified by the Maintenance Supervisor.	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations have revealed the	K 056	1. 14 sprinkler heads have been changed in the chapel to match the quick response sprinkler heads in the adjoining multi-purpose room. Breth-Zenzen Fire Protection Company completed this on April 13, 2015. 2. All data lines taped to sprinkler piping in the chapel storage room have been pulled out and rerouted. They are no longer affixed to piping. This was completed on March 30, 2015. Environmental Services Director is responsible to ensure these corrections are complete and for on-going compliance with any additional construction and when new data lines are installed.	4/13/15

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	245489	A. BUILDING **01 - 2004 BUILDING 2008 KITCHEN ADDITION** B. WING _____	**03/25/2015**

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K 056	Continued From page 10 following deficient conditions were found affecting the facility's Fire Sprinkler system, 1) the are two different type of sprinkler heads located in the chapel (standard response) and gathering area (quick response) which are combined in one compartment, 2) there are wires attached to the sprinkler piping that is located in the chapel storage room. This deficient practice was verified by the Maintenance Supervisor.	K 056		
K 074 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3	K 074		3/30/15

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K 074	Continued From page 11 This STANDARD is not met as evidenced by: Based on observations there are privacy curtains in the facility that do not meet the requirements for Furnishing, Bedding, and Decorations for use in health care occupancies in accordance with provisions of NFPA Life Safety Code 101 (2000 edition) section 19.7.5.1. This deficient practice could affect the exiting of 14 of 112 residents, staff and visitors. In the event of a fire in this space, smoke and fire could spread into the corridor making it untenable. Findings Include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, it was observed that the privacy curtain located in resident room 13 did not have any tags stating that the curtain is inherently fire retardant. This deficient practice was verified by the Maintenance Supervisor.	K 074	Privacy curtain located in room 13 has been replaced with a privacy curtain that has an affixed tag stating the curtain is fire retardant. This was completed on March 30, 2015. We have documentation that the privacy curtains in the TCU meet fire retardant standards. Documentation, including fabric samples, is located in our Life Safety book. The curtains did not have affixed tags. Environmental Services Director is responsible to ensure this correction is complete and for on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**03/25/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 - 2004 Addition and 2008 Kitchen Addition 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 Building 02 - 2004 Addition and 2008 Kitchen Addition was found not 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 18 New Health Care. 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		04/17/2015

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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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**03/25/2015**

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K 000	Continued From page 1 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 or 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 facility was inspected as 3 buildings: The Emmanuel Nursing Home built an addition in 2004 a separate building (building 02) that was constructed west of the 1963 main building. The 2004 addition is a 1-story building with a partial basement, which was determined to be of Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen expansion (building 02) was constructed to the south west corner of the 1963 building, that is a 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.	K 000		

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	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**03/25/2015**

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K 000	Continued From page 2 The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code and the 1997 and 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 112 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		3/30/15

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K 052	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, a review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection that the facility could not provide any current testing documentation for their fire alarm system. This deficient practice was verified by the Maintenance Supervisor.	K 052	1. Protection Systems, Inc. has provided annual testing documentation for the entire facility from their inspection on January 5, 2015. The missing documentation has been added to our life safety documentation book. This was completed on 3/26/15. All annual inspection reports will be kept in the Life Safety book. 2. The smoke detector located in the LTC dining room was relocated so that it is now a minimum of 36 inches away from HVAC diffuser. This was completed on March 30, 2015. Environmental Services Director is responsible for on-going compliance.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 056		3/26/15

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K 056	Continued From page 4 Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations have revealed that there are 3 escutcheon rings missing in the kitchen. This deficient practice was verified by the Maintenance Supervisor.	K 056	Three missing escutcheon rings in the kitchen ceiling have been replaced. This was completed March 26, 2015. Environmental Services Director is responsible to ensure this correction is complete and for on-going compliance.	
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4	K 073		3/26/15

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K 073	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations revieled that the following decorations were hanging on the corridor side of the resident room doors that were not treated with a fire retardant treatment, 1) Room 139 had a medium sized collage made of untreated wood on the door, 2) Room 124 had a stuffed animal hanging from the door. This deficient practice was verified by the Maintenance Supervisor.	K 073	Resident decorations hanging on corridor side of doors on rooms 139 and 124 were relocated to the inside of their rooms on March 26, 2015. All other corridor decorations will continue to be monitored to ensure they are a fire retardant treatment and meet standards. The residents involved, Environmental Services, Social Services, Nursing staff have all been educated on approved hallway decorations. All resident education will occur at the next resident council meeting. Responsible persons: Administrator, Environmental Services Director and Environmental Services staff are responsible for on-going compliance.	
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		3/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING **02 - 1963 MAIN BUILDING** B. WING _____	**03/25/2015**

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
K 147	Continued From page 6 Based on observation and interview with the staff the facility was using extension cords in place of permanent wiring that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 4 of 112 residents, staff and visitors. Findings include: On facility tour between 9:00 AM to 3:00 PM on 03/25/2015, observations revealed that an extension cord was found in resident room 141 and the mini refrigerator was plugged into a power strip and not directly into a wall outlet This deficient practice was verified by the Maintenance Supervisor.	K 147	Extension cord placed by resident family member was removed and the mini refrigerator was plugged directly into the wall outlet on March 26, 2015. All resident rooms were inspected. Residents and family members will be educated on correct safety practices at family and resident meetings. Responsible persons: Administrator, Environmental Services Director and Environmental Services staff for on-going compliance.	