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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UUJE

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 03/21/2013 (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 **120** (L18)

13.Total Certified Beds **120** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(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 :
Denise Erickson, HFE NEII 03/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/10/2013 (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 5/1/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/28/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5489

At the time of the Extended survey, the facility was not in substantial compliance with Federal certification regulations. The most serious deficiency was found at a scope and severity (S/S) level F Substandard Quality of Care.

Because the facility was subject to an extended survey and substandard quality of care, they are subject to a loss of NATCEP for a two year period.

Post Certification Revisit completed on March 21, 2013 to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and life safety code.

Effective March 1, 2013, the facility is certified for 92 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5489 April 10, 2013

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 March 1, 2013 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 92 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 10, 2013

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

RE: Project Number S5489021

Dear Ms. Green:

On February 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a extended survey, completed on January 31, 2013. 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 March 21, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 12, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a extended survey, completed on January 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 1, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 31, 2013, effective March 1, 2013 and therefore remedies outlined in our letter to you dated February 20, 2013, will not be imposed.

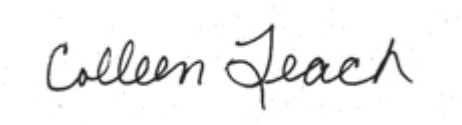
However, as we notified you in our letter of February 20, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 31, 2013.

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

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

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building B. Wing	3/21/2013

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 **F0176** Reg. # **483.10(n)** LSC	Correction Completed **02/28/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/01/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/01/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/28/2013**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0518** Reg. # **483.75(m)(2)** LSC	Correction Completed **03/01/2013**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/cbl	04/10/2013	31256	03/21/2013
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
1/31/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245489	01 - 2004 BUILDING 2008 KITCHEN ADDITI	3/12/2013

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 Reg. # NFPA 101 LSC K0056	02/15/2013	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/cbl	Date: 04/10/2013	Signature of Surveyor: 03006	Date: 03/12/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/5/2013		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

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245489	A. Building 02 - 1963 MAIN BUILDING B. Wing	3/12/2013

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 Reg. # NFPA 101 LSC K0056	02/15/2013	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/cbl	Date: 04/10/2013	Signature of Surveyor: 03006	Date: 03/12/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/5/2013		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: UUJE

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 **01/31/2013** (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 **120** (L18)

13.Total Certified Beds **120** (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

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
	120			
(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 :
Timothy Rhonemus, HFE NEII 03/05/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 03/27/2013 (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 3/28/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5489

At the time of the Extended survey, the facility was not in substantial compliance with Federal certification regulations. The most serious deficiency was found at a scope and severity (S/S) level F Substandard Quality of Care.

Because the facility was subject to an extended survey and substandard quality of care, they are subject to a loss of NATCEP for a two year period.

Post Certification Revisit to follow. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6157

February 20, 2013

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

RE: Project Number S5489021

Dear Ms. Green:

On February 5, 2013, an extended 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 and A Form whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) and A Form are enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

Telephone: (218) 332-5140

Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 12, 2013, 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 March 12, 2013 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Emmanuel Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective January 31, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 1, 2013 (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 July 31, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5489s13.rtf

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 _____	01/31/2013

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self administration of medication was safe for 1 of 1 resident (R120) in the sample self-administering a medication utilizing a nebulizer machine. Findings include: On 1/30/13, at 12:33 p.m. R120 was observed alone in her room, lying in bed. R120's eyes were closed, lying on her left side, with the head of the bed flat. A green elastic strap around her head held a green plastic nebulizer mask to her face. The nebulizer mask, with clear liquid in the	F 176		

Needed 3/5/13 Da

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janet Green — TITLE: Administrator — (X6) DATE: 2/22/13

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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F 176	Continued From page 1 medication chamber, was attached to a nebulizer machine near the bedside. The nebulizer machine was running, however, no mist and no bubbling of liquid in the medication chamber was observed. R120 remained sleeping, alone in her room with the nebulizer machine running until 12:45 p.m. At 12:45 p.m. registered nurse (RN) -D entered the room, aroused R120, and removed the mask after shutting off the nebulizer machine. R120 had diagnoses which included hyperactive airway disease and dementia. The significant change Minimum Data Set (MDS), dated 12/6/12, identified R120 had moderate cognitive impairment, and required extensive staff assistance for all areas of daily living. Review of the clinical record revealed a quarterly note, dated 12/12/12, identified R120 had problems understanding and being understood by others. The note identified R120 received scheduled Duonebs(medication administered via inhalation) for respiratory therapy management due to history of lung problems. The note identified treatments were always done by a trained licensed nurse and R120 was to be encouraged to cough, deep breath before, during and after treatments. However, the clinical record lacked documentation of the assessment for R120 to safely self administer medications. R120's care plan, dated December 2012, directed staff to utilize various interventions that included respiratoy therapy as ordered and medications and treatments as ordered. The care plan lacked direction for R120 to self administer the respiratory therapy treatments.	F 176	One nurse walked away from a resident during a nebulizer treatment. The resident had not been assessed to be safe with completing the treatment independently. The nurse was re-educated on the policy. All nurses reviewed the policy at a lane meeting or independently with his/her RN coordinator. The RN coordinators reviewed all residents receiving nebulizer treatments. The treatment/medication record reflects the individual resident's ability to self-administer medications and treatments. Random weekly audits X 4 weeks and then monthly audits X 3 will be performed to ensure that all nurses are following the policy. Any concerns will be brought to the nursing QA meeting. Responsible Persons: Clinical RN Coordinators, Director of Nursing	2-28-13

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F 176	Continued From page 2 Review of the physician orders, dated 1/10/13, included an order for Duoneb inhalation therapy routinely, however lacked an order for R120 to self administer the inhalation/respiratory medication. During interview on 1/30/13, at 1:01 p.m., RN-D stated, "[R120] has a lot of dementia." She confirmed R120 required staff assistance with ADLS for safety concerns. RN-D confirmed she routinely applied the nebulizer mask to R120 and left the room for 15 to 20 minutes while R120 received the medication via the nebulizer mask. During interview on 1/31/13, at 8:52 a.m. clinical manager (CM)-A confirmed R120 had cognitive impairment, safety issues and poor judgment. CM-A confirmed R120 had not been assessed for self administration of medications. CM-A stated "Staff should give the treatment and stay with her until done, she could get wrapped in the cords." CM-A confirmed staff are expected to stay with a resident until the nebulizer treatment is completed, unless a resident is assessed to be safe to self administer the nebulizer treatment. During interview on 1/31/13, at 1:28 p.m., the director of nursing (DON) confirmed residents are to be assessed, educated and monitored for safe self administration of medications including receiving nebulizer medications without staff present during the treatment . The DON stated the assessment was expected to be done prior to residents self administering medications. The facility policy titled Self Administration of Medications, revised May 2012, "2. If the resident	F 176		

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F 176	Continued From page 3 has expressed a desire to self administer, the interdisciplinary team will asses the resident's cognitive, physical and visual ability to carry out this responsibility. The facility may require that drugs be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make an assessment or until the care plan is completed within seven days upon completion of the comprehensive assessment. a comprehensive assessment." "4. Nursing is to get an order from the physician for self-administration of medications." No further policies were provided.	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 4 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report 3 of 3 incidents of resident to resident (R112, R106, R94) abuse to the state agency and or the administrator, and failed to report 1 of 1 (R151) incidents of significant injury of unknown origin to the State agency. Findings include: The Resident Incident Report dated 12/28/12, at 8:00 p.m., indicated an unidentified male resident was sitting in a recliner when R112 got close to him making him upset which caused the resident to slap R112 which in turn R112 slapped this resident back. This incident of resident to resident abuse was not reported to the State agency, although the administrator had been notified one hour and fifteen minutes after the occurence. The Resident Incident Report dated 12/28/12, at	F 225	We understand all reports of abuse or suspected abuse need to be filed immediately according to federal regulations and the state of MN vulnerable adult act. We use the regulations to assist us with determining what is reportable (abuse, neglect, mistreatment). At the time of the 3 incidents of resident to resident abuse we had determined that there was no willful intent of harm and no injuries. The residents involved all have a diagnosis of Alzheimer's or related dementia. Behavior modification plans were in place and updated to improve safety of residents as incidents occurred. Resident #112 was being treated by a psychiatrist and we were in the process of receiving approval and transferring to a specialty behavioral health hospital program for evaluation and treatment ASAP. Resident #112 was transferred to the Grand Forks Hospital, Behavior Health Unit, on 1/2/13.	3/1/13

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F 225	Continued From page 5 8:00 p.m. indicated R112 slapped R106.This incident of resident to resident abuse was not reported to the State agency, although the administrator had been notified one hour and fifteen minutes after the occurence. The Resident Incident Report dated 12/29/12, at 6:50 a.m. indicated R112 got into another unidentified residents face and started to hit him. The report also indicated R112 was observed "hitting" this other resident. This resident to resident abuse incident was not reported to the State agency. It was unable to determine when the administrator had been notified of the occurence. The Resident incident Report dated 12/30/12, at 7:00 a.m. indicated R112 got into R94's face, words were exchanged and R112 slapped R94 across the face. This resident to resident abuse incident was not reported to the State agency. It was unable to be determined when the administrator had been notified of the occurence. The Resident Incident Report dated 12/30/12, at 7:00 a.m. indicated R94 was in a verbal altercation with R112 when R112 slapped R94 across the face. This resident to resident abuse incident was not reported to the State agency. It was unable to be determined when the administrator had been notified of the occurence. R151 sustained an unwitnessed significant injury and the facility failed to report it to the State agency. The Resident Incident Report dated 1/16/13, indicated R151 was found laying on the floor in	F 225	We have updated education, policies and procedures relating to managing and reporting resident to resident altercations. All resident to resident altercations will be reported as potential abuse effective 2/20/13. All potential or suspected abuse will continue to be reported immediately to the Administrator or designated representative/DON. An internal investigation was completed on R151 who was found laying on the floor next to her bed and had a fractured hip. Staff had assisted the resident to lay on her bed "shortly" before the incident. Staff in the area did not observe any visitors, staff or residents entering the room. The resident was ambulatory and able to walk to the dining room with assistance. The assessment/internal investigation determined that the plan of care was being followed, was appropriate and there was no indication of mistreatment. We had determined it was an accident and not reportable.	

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F 225	Continued From page 6 her own room. The report also indicated R151 had complained of hip pain and was sent to the emergency room for evaluation. The report further indicated R151 was diagnosed with a hip fracture that required surgical repair. The documentation identified the administrator had been notified via a 24 hour report log utilized by the facillity. On 1/30/13, at 8:28 a.m. clinical manager (CM) -A stated resident to resident abuse and a fracture of a long bone/hip were to be reported to the State agency. She stated when a resident to resident altercation occurred staff would contact the DON and the DON would take it from there if it needed to be reported to the State agency. However, CM-A stated if a resident to resident abuse incident occurred on the dementia unit she would not report it to the State agency because those residents "don't know any better." At 1:16 p.m. nursing assistant (NA)-A stated when resident to resident altercations occurred they would report it to the charge nurse. NA-A also verified R151 was found on the floor at the foot of the bed when the fracture occurred. At 1:41 p.m. licensed practical nurse (LPN)-A stated that when a resident to resident altercation occurred the LPN would complete the Resident Incident Report and inform the registered nurse/supervisor on duty. LPN-A stated the registered nurse/supervisor was responsible to inform the director of nursing (DON) of the incident. LPN-A verified R151 was found on the floor when the fracture occurred. LPN-A added, R151 had been in bed prior to the fall. Additionally, LPN-A stated she would think a	F 225	unexplained Effective 2/20/13 all ~~unwittnessed~~ injuries requiring physician attention will be immediately reported in accordance with state law; followed by a thorough investigation. Education will be completed by 3/1/13. All incidents of suspected abuse will be reviewed by the QA committee. Responsible Persons: DON and Administrator	

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F 225	Continued From page 7 fracture from an unwitnessed fall should be reported to the State agency. On 1/31/13, at 6:33 a.m. registered nurse (RN)-A stated R112 would poke other residents, pick fights with them until they yelled out. RN-A stated staff attempted to keep R112 away from other residents, however, stated that did not work. Additionally, RN-A verified resident to resident altercations "happens" on the secured dementia unit. RN-A stated when resident to resident contact occurred a Resident Incident Report would be completed and given to the clinical manager or shift supervisor who in turn informed the DON. Additionally, RN-A stated she did not report incidents to the State agency, only to the shift supervisor. RN-A also stated reporting to the State agency is done by the supervisor. At 8:58 a.m. CM-B, clinical manager of the dementia unit, verified she received and reviewed for completion all of the resident incident reports for the dementia unit. CM-B stated the facility utilized a "24 hour" report form, which was completed throughout each 24 hour period on each wing of the facility. The evening shift supervisor then complied the data from each wing, and at the end of the shift sent an email to all managers in the facility. CM-B stated however, if a resident had been injured, staff would immediately notify the DON/Administrator by email or phone. CM-B also verified the referenced resident to resident abuse incidents were not reported to the State agency because none of them caused an physical injury. CM-B added, resident to resident altercations were only reportable to the State agency when a resident was injured.	F 225		

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F 225	Continued From page 8 At 9:44 a.m. CM-B verified R151's fall was unwitnessed and stated it was assumed R151 fell because it happened not long after staff had assisted her into bed. CM-B also stated R151's fall/fracture was not and would not be reported to the State agency because neglect had not occurred. At 9:51 a.m. the DON verified the referenced resident to resident abuse incident reports were not reported to the State agency. She confirmed the facility utilized a 24 hour report form, which was reviewed by managers the next working day. Additionally, the DON stated the facility would only report resident to resident abuse incidents if a resident had shown intent to harm, was willful. When asked if a resident with cognitive impairment could show intent the DON responded "probably not." The DON stated none of the referenced incident reports had indicated that a resident had intent to harm another resident therefore, was deemed non-reportable. In addition, the DON verified a fractured hip was a significant injury, however, stated a fracture was not necessarily reportable. The DON added, R151 was found on the floor next to the bed which led them to believe she had fallen out of bed. The DON verified R151's unwitnessed significant injury was not reported to the State agency. At 10:30 a.m. the director of social services (DSS) joined the above interview and verified the referenced resident to resident abuse incidents were not reported to the State agency. However, the DSS did verify and stated the 12/30/12 incident with the verbal altercation leading to the	F 225		

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F 225	Continued From page 9 residents slapping each other did show willful intent. Both the DON and DSS verified a resident could have been hurt, however, stated no facial redness had occurred thus stated, "How much of a slap was it." At this time both the DON and the DSS verified the current facility abuse prohibition policy and procedures and verified the policy lacked identification of resident to resident abuse. The DSS stated resident to resident abuse should have been included in the facility abuse policy and procedures. The Abuse Prevention Plan For Minnesota Skilled Nursing Facilities dated 12/16/11, indicated on page 13 section G that an injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury. Review of the facility Reporting Reasonable Suspicion Of A Crime policy and procedure dated 9/2011, and the facility Abuse Prevention Plan For Minnesota Skilled Nursing Facilities policy and procedure dated 12/16/11, revealed both policy and procedures lacked identification of the required resident to resident abuse component.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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 _____	01/31/2013

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 226	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and and implement a abuse prohibition policy, which included resident to resident abuse, and failed to implement the facility policy regarding immediate notification of the administrator. This practice had the potential to affect all 114 residents currently residing within the facility. Furthermore, the facility failed to provide employee orientation for new employees upon hire for 3 of 4 newly hired staff (NA-N, DA-O, DA-P) reviewed. Findings include : The following incidents of resident to resident altercation and injury of unknown origin were not reported to the State agency as required: The Resident Incident Report dated 12/30/12, indicated R94 was in a verbal altercation with R112 when R112 slapped R94 across the face. The Resident Incident Report dated 12/30/12, indicated R112 got into R94's face, words were exchanged and R112 slapped R94 across the face. The Resident Incident Report dated 12/29/12, indicated R112 got into R106's face and started to hit R106. The Resident Incident Report dated 12/28/12, indicated R112 was too close R106 which caused R106 to slap R112 and in return R112 slapped R106 back.	F 226	The current policy will be improved and will include specific information regarding resident to resident abuse by 3/1/13 as an addendum to the Ecumen policy. Education for all staff will be provided. A new abuse prevention form has been developed, education completed, and is being used effective 2/8/13. This includes immediate notification of the administrator with signature to verify that the administrator was contacted. Orientation for new employees effective 3/1/13 includes education upon hire regarding the abuse prohibition policy. New employee interviews and paper compliance audits will be completed monthly, every three months, and then random audits. Issues will be reviewed by QA committee to ensure on-going compliance. Responsible Persons: Human Resources Director, DON, and Administrator	3/1/13

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F 226	Continued From page 11 The Resident Incident Report dated 1/16/13, indicated R151 was found on the floor in her own room. The report also indicated R151 had complained of hip pain thus was sent to the emergency room for evaluation. The report further indicated R151 was diagnosed with a hip fracture that required surgical repair. In addition, the following incidents of resident to resident altercation had not been reported immediately to the administrator: The Resident Incident Report dated 12/30/12, indicated R94 was in a verbal altercation with R112 when R112 slapped R94 across the face. It was unable to be determined when the administrator was notified of this occurence. The Resident Incident Report dated 12/30/12, indicated R112 got into R94's face, words were exchanged and R112 slapped R94 across the face. It was unable to be determined when the administrator was notified of this occurence. The Resident Incident Report dated 12/29/12, indicated R112 got into R106's face and started to hit R106. It was unable to be determined when the administrator was notified of this occurence. On 1/31/13, at 9:51 a.m. the DON verified the above incidents were not reported to the State agency. The DON stated when R151 was found on the floor it was assumed she had fallen therefore was not reported to the State agency. Additionally, the DON verified the facility's Abuse Prevention Plan policy and procedure lacked the required resident to resident abuse component.	F 226		

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F 226	Continued From page 12 The DON verified the various facility managers, which included the administrator, were notified after the 24 hour data had been compiled by the evening supervisor. On 1/3/13, at 10:30 a.m. During review of the facility Reporting Reasonable Suspicion Of A Crime policy and procedure dated 9/2011, and the facility Abuse Prevention Plan For Minnesota Skilled Nursing Facilities policy and procedure dated 12/16/11, with the DON and director of social services (DSS), they both stated they were unable to find the policy requirement related to the resident to resident abuse component. After review of the policies and procedures,both the DON and DSS verified the policy lacked this requirement. Additionally, the DSS also verified the referenced incidents were not reported to the State agency as required. Page 6, Section E. of the facility Abuse Prevention Plan For Minnesota Skilled Nursing Facilities policy and procedure dated 12/16/11, identified abuse as "the willful infliction of injury, intimidation, or punishment with resulting harm, pain or mental anguish. The policy further identified physical abuse as "hitting, slapping, pinching and kicking."	F 226		

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F 226	Continued From page 13 EMPLOYEE TRAINING NA (nursing assistant) -N was hired on 08/27/12. Review of the employee record indicated the new employee orientation was completed on 11/19/2012. DA (dining assistant)-O was hired on 08/02/2012. Review of the employee record indicated the new employee orientation was completed on 08/29/2012. DA-P was hired on 07/27/2012. Review of the employee record indicated the new employee orientation was completed on 08/29/2012. In interview with the human resource supervisor (HRS), on 01/31/2013, HRS stated that the facility provided new employees a booklet (undated) entitled: Welcome to Ecumen Detroit Lakes Self-Directed Orientation for New Employees. HRS stated that this initial new employee meeting was approximately 2 hours. Within the following 1-2 months, new employees recently hired, would attend 6 hours general orientation. HSR verified that initial training was employee self directed, included the locations of manuals and directed the employee what to read within the facility's policies manuals. The facility's policy, entitled: "Section C: Employee Policies & Practices - Orientation (revision date: April 2011) - did not indicated the time frame for which new employee orientation would be performed, but rather the purpose behind the training.	F 226		

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F 226	Continued From page 14 No further information was provided.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 1 residents (R42) in the sample who utilized a safety alarm. Furthermore, the the facility failed to revise the care plan for 1 of 1 residents (R82) in the sample who utilized a positioning device. Findings include:	F 280	Two plans of care did not list either a safety device or a positioning device. These items were accidently taken off of the current plan of care the last time they were updated. All staff members were using the devices appropriately and correctly. The IDT members reviewed all of the resident care plans for accuracy. The RNs will compare the old and new care plans each time they are re-printed to ensure that all of the current information is printed on the new care plan. Any concerns will be brought to the IDT QA meeting. Random audits will be completed in one month to ensure compliance and then random audits to maintain accuracy and for ongoing compliance. Responsible Persons: Clinical and MDS RN Coordinators, DON	2-28-13

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F 280	Continued From page 15 Chair Alarm R42's diagnoses included thoracic compression fractures, cognitive impairment, deconditioning and right foot drop. The admission Minimum Data Set (MDS), dated 12/03/12, identified R42 had moderate cognitive impairment and required extensive assistance of staff to transfer and ambulate. The Care Area Assessment (CAA), dated 12/7/12, identified R42 had a history of falls with compression fractures of the spine. The CAA identified R42's continued high risk for falls and identified risk factors of: "history of fall noted resulting in vertebral compression fracture, using a walker for some mobility, weakness, vision is also slightly impaired." The care plan, revised 1/16/13, directed staff to utilize various interventions that included a low bed and concave mattress. However, lacked direction to utilize a safety alarm for the R42. On 1/30/13, at 9:56 a.m. R42 was observed sitting in chair in room with TABS alarm securely attached to the chair and the back of R52's shirt. At 12:37 p.m., R42 was observed sitting in her room, with TABS alarm in place. Review of the physical therapy note, dated 12/24/12, identified R42 "not safe to ambulate independent." Review of the occupational therapy note, dated 12/24/12, identified fall interventions in place, and identified R42 would always need assistance with mobility for safety, and had poor safety awareness.	F 280		

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F 280	Continued From page 16 During interview on 1/31/13 , at 3:21 p.m., clinical manager (CM)-C confirmed R42 needed assistance for all activities of daily living, including walking to the bathroom. She stated R42 was "unsafe to ambulate alone", and needed an alarm to prevent falls. CM-C stated R42 routinely self transferred and an alarm was to be used at all times. She confirmed R42's care plan had not been revised to include direction for alarm use. CM-C stated she would expect the care plan to direct all staff to utilize alarms to ensure R42's safety During interview on 1/31/13, at 1:28 p.m., the director of nursing (DON) confirmed the lack of documentation in the care plan for use of the safety alarm. She indicated she would expect all fall prevention interventions to be included on the care plan to ensure resident safety. Foot Strap R82's current care plan dated October 2012, did not address the need, or give direction for the use of a positioning device to ensure R82 comfort and prevent left foot from falling off of the wheel chair pedal. R82's diagnoses included diabetes, hemiparesis, neuropathy, and muscle weakness. The significant change MDS, dated 9/27/12, identified R82 had severe cognitive impairment, required extensive assistance for hygiene, transfer, bed mobility and total assistance for locomotion. The current care plan, dated December 2012,	F 280		

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F 280	Continued From page 17 identified R82 had late effects of cerebrovascular accident (stroke) with paralysis on one side of the body, both short and long term memory problems and diabetes. The care plan identified R82 had poor decision making skills, directed staff to anticipate her needs, however, lacked direction for the use of a positioning device for R82 On 1/30/13, at 7:01 a.m., R82 was observed sitting in wheel chair with a wide blue foam strap in place around her left leg and the leg rest of wheelchair. On 1/31/13, at 9:04 a.m., R82 was sitting in a wheel chair near the bed watching television, with left leg secured with a wide blue foam strap to the leg of the wheelchair. Review of the clinical record revealed an occupational therapy recommendation, dated 11/22/11, identified R82's left leg was at risk for injury due to extension of the leg, recommended to secure foot on footrest, and to secure leg into place with foam strapping. In addition, the staff were to monitor comfort level, and monitor for any pressure areas or concerns with the strap. On 1/31/13, at 9:06 a.m., R82 stated the leg "will pinch" when leg falls from the pedal of the wheelchair. During interview on 1/31/13, at 9:29 a.m., registered nurse (RN)-F stated she was unaware of when or who initiated the use of the blue foam strap for R82. She stated she had seen the blue strap used for R82 in the past, however confirmed R82's care plan did not direct staff to utilize the strap.	F 280		

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F 280	Continued From page 18 During interview on 1/31/13, at 1:28 p.m., the director of nursing (DON) confirmed R82's current care plan and clinical record findings. She stated she would expect the care plan to include directions on the proper placement and use of the foam strap for R82. The facility policy titled Care Planning IDT, revised May 2011, identified care plans would be used by all personnel involved in the care of the resident and would be updated on an ongoing basis to reflect resident individual needs.	F 280		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete performance evaluations on an annual basis for 3 of 4 employees (NA-E, NA-F, NA-H) reviewed who had been employed for more than 12 months.	F 497		

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F 497	Continued From page 19 Findings include: A review of employee files conducted during extended survey revealed the following: NA (nursing assistant)-E was hired on 05/23/2005. Review of the employee record indicated that the last annual performance evaluation had been completed on 08/08/2011. NA-F was hired on 05/19/2003. Review of the employee record indicated that the last annual performance evaluation had been completed on 08/02/2011. NA-H was hired on 07/22/1976. Review of the employee record indicated that the last annual performance evaluation had been completed on 01/31/13 during the extended survey. During interview on 01/31/13 at 3:20 p.m., a registered nurse (RN-C), who performed the evaluation for NA-H, verified it had been done that day after survey team requested review of NA-H's employee file. RN-C stated that she thought it had been completed in June 2012, but she was not able to locate the paperwork. The facility's policy, entitled: "Section C: Employee Policies & Practices - Performance Reviews, revised 4/11, identified "In order to help build confident, competent and satisfied employees, Ecumen strives to evaluate the work performance of each employee after the initial employment period and annually during employment."	F 497	Annual performance evaluations were not completed on 100% of staff members within a 12 month time frame. All nursing home employees have a current annual performance evaluations completed effective 2-19-13. A new computer system of tracking and notifying when a performance evaluation is due was implemented. Evaluations will be initiated prior to the due date to assist with compliance. Performance evaluations will be completed within 12 months from the last evaluation. Managers were trained on the new procedure on 2-12-13. The Administrator will do quarterly audits to ensure compliance. Responsible Persons: Human Resource Director, Administrator	2-19-13

more freq audits at first then

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F 497	Continued From page 20 On 01/31/13 at 3:35 p.m. the facility administrator (ADM) stated her standard was that full time employees should have evaluations completed between 12-15 months, and part time employees 15-18 months. The ADM verified that the performance evaluations had not been completed and should have been, in accordance with the facility policy. No further information was provided.	F 497		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure training on facility's emergency procedures for 4 of 4 newly hired employees (NA-N, DA-O, DA-P and NA-M) reviewed during the extended survey. Findings include: NA (nursing assistant) -N was hired on 08/27/12. Review of the employee record indicated that the new employee orientation was completed on 11/19/2012. DA (dining assistant)-O was hired on 08/02/2012. Review of the employee record indicated that the	F 518		

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F 518	Continued From page 21 new employee orientation was completed on 08/29/2012. DA-P was hired on 07/27/2012. Review of the employee record indicated that the new employee orientation was completed on 08/29/2012. NA-M was hired on 09/20/2012. Review of the employee record indicated that the new employee orientation had been completed on 11/19/12. During interview with the human resource supervisor (HRS), on 01/31/2013, at 10:14 a.m., HRS stated that the facility provided a new employee a booklet (undated) entitled: Welcome to Ecumen Detroit Lakes Self-Directed Orientation for New Employees. HRS stated that this initial new employee meeting was approximately 2 hours. Within the following 1-2 months, new employees recently hired, would attend a more in-depth general orientation. HSR verified that initial training was employee self directed by the employee booklet which included locations of emergency manuals and what to read within the facility's policies manuals. The facility's policy, entitled: "Section C: Employee Policies & Practices - Orientation (revision date: April 2011) - did not indicated the time frame for which new employee orientation would be performed, but rather the purpose behind the training. No further information was provided.	F 518	Effective 3/1/13 A new and improved employee orientation process will be implemented which includes additional time spent in person training new employees in important information with emphasis on abuse prohibition and emergency procedures. This is in addition to the current self-directed modules that will continue to be used to reinforce training. The policy has been updated and indicates in addition to stating the purpose behind the training that training will be completed upon hire covering abuse prohibition and emergency response. Within the first three working days of employment all general orientation will be completed. Administrator will complete periodic interviews and paper audits to ensure ongoing compliance. Responsible person: Director of Human Resources, Administrator	3/1/13

F225 – E Reporting Potential Vulnerable Adult Incidents

We understand all reports of abuse or suspected abuse need to be filed immediately according to federal regulations and the state of MN vulnerable adult act. We use the regulations to assist us with determining what is reportable (abuse, neglect, mistreatment).

At the time of the 3 incidents of resident to resident abuse we had determined that there was no willful intent of harm and no injuries. The residents involved all have a diagnosis of Alzheimer's or related dementia. Behavior modification plans were in place and updated to improve safety of residents as incidents occurred. Resident #112 was being treated by a psychiatrist and we were in the process of receiving approval and transferring to a specialty behavioral health hospital program for evaluation and treatment ASAP. Resident #112 was transferred to the Grand Forks Hospital, Behavior Health Unit, on 1/2/13.

We have updated education, policies and procedures relating to managing and reporting resident to resident altercations. All resident to resident altercations will be reported as potential abuse effective 2/20/13. All potential or suspected abuse will continue to be reported immediately to the Administrator or designated representative/DON.

3/3/13
addendum
OK DA

An internal investigation was completed on R151 who was found laying on the floor next to her bed and had a fractured hip. Staff had assisted the resident to lay on her bed "shortly" before the incident. Staff in the area did not observe any visitors, staff or residents entering the room. The resident was ambulatory and able to walk to the dining room with assistance.

The assessment/internal investigation determined that the plan of care was being followed, was appropriate and there was no indication of mistreatment. We had determined it was an accident and not reportable.

Effective 2/20/13 all unexplained injuries requiring physician attention will be immediately reported in accordance with state law; followed by a thorough investigation.

Education will be completed by 3/1/13.

All incidents of suspected abuse will be reviewed immediately and the administrator will be notified immediately. Ongoing audits (of all incidents) to ensure compliance with notification and follow up will be conducted. Results of these audits will be reviewed by the QA committee.

Responsible Persons:
DON and Administrator

Completion Date
3/1/13

F226 – F Abuse Prevention Plan

The current policy will be improved and will include specific information regarding resident to resident abuse by 3/1/13 as an addendum to the Ecumen policy. Education for all staff will be provided.

A new abuse prevention form has been developed, education completed, and is being used effective 2/8/13. This includes immediate notification of the administrator with signature to verify that the administrator was contacted.

Ongoing audits (of all incidents) to ensure compliance with the policy, the new form and immediate notification of the administrator will be conducted.

Orientation for new employees effective 3/1/13 includes education upon hire regarding the abuse prohibition policy.

New employee interviews and paper compliance audits will be completed monthly X 3, every three months, and then random audits. Issues will be reviewed by QA committee to ensure on-going compliance.

Responsible Persons: Human Resources Director, DON, and Administrator

Completion Date:
3/1/13

F 497 – E Annual Performance Evaluations

Annual performance evaluations were not completed on 100% of staff members within a 12 month time frame.

All nursing home employees have a current annual performance evaluations completed effective 2-19-13. A new computer system of tracking and notifying when a performance evaluation is due was implemented. Evaluations will be initiated prior to the due date to assist with compliance. Performance evaluations will be completed within 12 months from the last evaluation. Managers were trained on the new procedure on 2-12-13.

The Administrator will do monthly audits X6 and then quarterly audits to ensure compliance.

Responsible Persons: Human Resource Director, Administrator

Completion Date: 2-19-13

F518 –E Training for emergencies and other disasters

Effective 3/1/13
A new and improved employee orientation process will be implemented which includes additional time spent in person training new employees in important information with emphasis on abuse prohibition and emergency procedures. This is in addition to the current self-directed modules that will continue to be used to reinforce training.

The policy has been updated and indicates in addition to stating the purpose behind the training that training will be completed upon hire covering abuse prohibition and emergency response. Within the first three working days of employment all general orientation will be completed.

Administrator will complete monthly employee interviews concerning the employees' orientation and knowledge of emergency procedures and abuse prevention and paper audits of the training given X 3 months and then quarterly to ensure ongoing compliance.

Responsible person: Director of Human Resources, Administrator

Completion Date:

3/1/13

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 KITC B. WING _____	02/05/2013

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 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. At the time of this survey Emmanuel Nursing Home 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 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	Emmanuel nursing home is currently licensed for 120 beds. POC JB 3-1-13 RECEIVED FEB 28 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 03.18.2013

EXIT: 02.06.2013

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

Janet Green, Administrator 2/22/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING 01 - 2004 BUILDING 2008 KITC B. WING _____	02/05/2013

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 Or by e-mail to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 additions to the east and west wings were constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without a basement and which is a Type II (111)	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 01 - 2004 BUILDING 2008 KITC B. WING _____	02/05/2013

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 construction. In 2004 a separate building was constructed west of the 1963 main building, is 1-story with a partial basement, which is a Type II (000) construction and separated with a 2-hour fire rated barrier. In 2008 a kitchen expansion was constructed to the south west corner of the 1963 building, is 1-story, full basement and is separated form the new assisted living building with a 2-hour fire barrier and was determined to be Type II (111) construction. The building is completely protected with an automatic fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code and the 1997 and 2004 additions have single station smoke detection in the sleeping rooms that annunciates at the respective nurse's stations in accordance with the Minnesota State Fire Code 2007 edition. The building is divided into 9 smoke zones by 30 minute, 1 hour and 90 minute fire barriers. Because the original building and its additions meet the construction type allowed for existing buildings and the 2004 building and the 2008 kitchen addition, meet new building requirements the LSC, this facility was surveyed as a two buildings, one existing and one new.	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 01 - 2004 BUILDING 2008 KITC B. WING _____	02/05/2013

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 3 The facility has a capacity of 140 beds and had a census of 115 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	Emmanuel nursing home is currently licensed for 120 beds.	
K 056 SS=C	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: Observations revealed that the automatic fire sprinkler system is not maintained in accordance with NFPA 25 Standard for Inspection, Testing and Maintenance of a Water-Based Fire protection System, 1998 edition section 6-3.6. This deficient practice may allow a fire to grow which will negatively impact all the patients, visitors and staff. Findings include: During the facility tour of February 5, 2013, between 9:30 am and 12:30 pm, surveyor 03006 revealed that the sprinkler system gauges could	K 056	The automated sprinkler system is inspected annually by Nova, an authorized/certified fire protection company. As of 2/15/13 all gauges have been replaced, labeled and dated. Periodic audits will be completed to ensure that the labels are intact and that all gauges are replaced every 5 years. This task has been added to the computerized preventative maintenance program to ensure ongoing compliance. The Environmental Services Director is responsible for ongoing compliance.	2/15/13

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	245489	A. BUILDING 01 - 2004 BUILDING 2008 KITC B. WING _____	02/05/2013

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 056	Continued From page 4 not be documented as being replaced nor re-calibrated within the past 5 years. The Director of Maintenance (PR) verified these findings during the tour of the facility.	K 056		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245489	MULTIPLE CONSTRUCTION A. BUILDING 01 - 2004 BUILDING 2008 B. WING	DATE SURVEY COMPLETE: 2/5/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Observations of all the exits and exit discharges revealed that some exit discharges are obstructed and do not comply with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.2.3. This deficient practice could negatively affect all residents, staff and visitors that need to be quickly evacuated through these exits. Findings include: During the facility tour of February 5, 2013, between 9:30 am and 12:30 pm, revealed that four of eight exit discharges, including the Post Acute Care east, Oak Lane east, Oak Lane west, and Birch Lane east were covered with snow that had blown in. (Staff was immediately dispatched to start removing the snow) The Director of Maintenance (PR) verified these findings during the tour of the facility.

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

The above isolated deficiencies pose no actual harm to the residents

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 _____	02/05/2013

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

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K 000	INITIAL COMMENTS FIRE SAFETY 02 2004 Building and 2008 Kitchen Addition 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. At the time of this survey Emmanuel Nursing Home 02 2004 Building 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 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	POC ok JB 3-1-13 RECEIVED FEB 28 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Janet Green | Administrator | 2/22/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Emmanuel Nursing Home was built in 1963 as a 1-story building with a partial walkout basement and was determined to be Type II (111) construction. In 1966 additions to the east and west wings were constructed, are 1-story without basements and are Type II (111) construction. In 1978 an addition to the north of the north wing of the 1963 building was constructed, is 1-story with a partial basement, was determined to be of Type II (000) construction, and is separated with a 2-hour fire barrier. A chapel addition was constructed in 1992 and attached to the south of the 1963 building, is 1-story with a basement and was determined to be of Type II (000) construction. In 1997 a sleeping room addition was constructed to the west of the 1978 addition, is one story without	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245489	A. BUILDING 02 - 1963 MAIN BUILDING B. WING _____	02/05/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 3 The facility has a capacity of 140 beds and had a census of 115 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	Emmanuel nursing home is currently licensed for 120 beds.	
K 056 SS=C	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 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: Observations revealed that the automatic fire sprinkler system is not maintained in accordance with NFPA 25 Standard for Inspection, Testing and Maintenance of a Water-Based Fire protection System, 1998 edition section 6-3.6. This deficient practice may allow a fire to grow which will negatively impact all the patients, visitors and staff. Findings include: During the facility tour of February 5, 2013,	K 056	The automated sprinkler system is inspected annually by Nova, an authorized/certified fire protection company. As of 2/15/13 all gauges have been replaced, labeled and dated. Periodic audits will be completed to ensure that the labels are intact and that all gauges are replaced every 5 years. This task has been added to the computerized preventative maintenance program to ensure ongoing compliance. The Environmental Services Director is responsible for ongoing compliance.	2/15/13

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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 056	Continued From page 4 between 9:30 am and 12:30 pm, surveyor 03006 revealed that the sprinkler system gauges could not be documented as being replaced nor re-calibrated within the past 5 years. The Director of Maintenance (PR) verified these findings during the tour of the facility.	K 056		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245489	MULTIPLE CONSTRUCTION A. BUILDING 02 - 1963 MAIN BUILDIN B. WING	DATE SURVEY COMPLETE: 2/5/2013
NAME OF PROVIDER OR SUPPLIER: EMMANUEL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE: 1415 MADISON AVENUE DETROIT LAKES, MN		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Observations of all the exits and exit discharges revealed that some exit discharges are obstructed and do not comply with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.2.3. This deficient practice could negatively affect all residents, staff and visitors that need to be quickly evacuated through these exits. Findings include: During the facility tour of February 5, 2013, between 9:30 am and 12:30 pm, revealed that: 1) Relocate or remove the seating furniture across from the main office to insure an 8 foot wide corridor. (Staff immediately relocates the furniture) 2) Four of eight exit discharges, including the Post Acute Care east, Oak Lane east, Oak Lane west, and Birch Lane east were covered with snow that had blown in. (Staff was immediately dispatched to start removing the snow) The Director of Maintenance (PR) verified these findings during the tour of the facility.

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

The above isolated deficiencies pose no actual harm to the residents